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This revised strategy have been produced and approved by the NABIS and the National Criminal Use of Firearms Group. It has been approved by NCOCC and VPP portfolio lead. The operational implementation of all guidance and strategy will require operational choices to be made at local level in order to achieve the appropriate police response and this document should be used in conjunction with other existing Authorised Professional Practice (APP) produced by the College of Policing. It will be updated and re-published as necessary.

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1. Victims of shootings

1.1. Safeguarding Victims of shootings (non-fatal)

Key points

- **Non-fatal victims of shooting should be subject of an immediate threat to life assessment.**
- **Police, in particular offender managers, should not overlook the increased risk of non-fatal shooting victims becoming perpetrators of gun crime themselves or falling victim of a further shooting incident in the future.**
- **Actions arising from a threat to life assessment must be aligned to any coexisting offender management strategy.**
- **Those working with the victim in an offender management capacity must be fully sighted on the threat to life assessment to ensure their own safety can be maintained.**
- **Considerations must be made in relation to all other persons deemed to be at risk. This may include: intended targets, family, friend, linked or opposing gang members.**
- **Child safeguarding considerations must be undertaken in respect of children linked to any person deemed to be at risk. Police protection procedures should be considered and any decisions clearly recorded.**

There is evidence that patients admitted to hospital with firearm related injuries are at increased risk of subsequent firearm related victimisation or crime perpetration (Rowhani-Rahbar et al. 2015: 496). Indeed, in US research, they found that those patients with prior firearm related criminality had a high likelihood of being murdered within five years of their hospitalisation (Rowhani-Rahbar et al. 2015: 496). Notwithstanding the differences between US and UK culture, it is perhaps useful, for those working with gangs and young people, to keep this in mind when formulating an offender management strategy.

Victims of shooting incidents, suffering non-fatal injuries, should always be considered to be at high risk, and an immediate threat to life assessment should be undertaken in accordance with the ACPO National Threats to Life Guidance 2012

If it is suspected that the victim is involved in criminality then, alongside the threat to life considerations, there should be a coexisting offender management plan. It is essential that both these pieces of work are coordinated to ensure that the activity undertaken in respect of

one does not compromise the other. Importantly, offender managers need to be fully sighted on the intelligence around risk so they understand the context within which they are working and can ensure their own safety as well as that of others.

An immediate assessment must be made in terms of who else may be at risk, this could include family members, friends, those living close by, or possibly, intended targets. Where there is found to be a risk, a threat to life assessment must be undertaken without delay.

In relation to children, either present at the scene, living with the victim, or with any other person identified as being at risk, officers must take immediate and proportionate safeguarding measures. Consideration must be given to using police protection procedures. It is essential that police considerations, decisions and rationale are recorded and regularly reviewed.

1.2. Victims at hospital

Key Points

- **Deploying armed officer to hospitals to safeguard the victim, medical staff, public and officers should always be an urgent police consideration following a shooting incident. The same consideration should also be given in cases where a hospital notify the police that they have received a shooting victim, even where the police have had no reports themselves and the scene is not known.**
- **Armed officers attending a hospital to protect victim, medical staff, or officers must ensure they do not cross contaminate scenes. This includes the victim, their possessions, and any suspects (including those who may become suspects in the future).**

It is not uncommon, and should always be a police consideration following a non-fatal shooting, to place an armed guard at any place a victim is taken to. This is to ensure continued protection of the victim, those treating him/her, the wider community, and police responders who may also be in attendance.

It is important that parameters are set for this armed guard; they must not be involved in the forensic recovery of samples/clothing from the victim. They should do everything possible to ensure they have no physical contact with the victim, the victim's clothing/personal affects, or anything the victim is likely to come in contact with prior to the victim samples being secured.

One of the fundamental reasons for an armed guard being placed with a victim is to mitigate the risk of the offenders returning to cause further serious harm, kill the victim or even simply communicate with, or unduly influence them. Armed officers should maintain an expectation that such persons will come to the hospital or other place the victim is at, and therefore, must ensure that they are not going to pass trace evidence from the victim to any suspect who may be apprehended at that time, or become a suspect and arrested at a further point in time.

1.3. Victim related samples (non-fatal)

Key Points

- **Victims are potentially a rich source of forensic evidence**
- **Use uncontaminated officers, keep any armed officers away**
- **Photograph victim**
- **Obtain/request pre-transfusion blood sample**
- **Obtain contact trace material (swabbing, combing, scrapings, and clothing)**
- **Bag each item separately**
- **Use paper bags with a clear window if possible**
- **If possible, get the victim to undress on a sheet of brown paper, which should then also be bagged and exhibited separately**
- **Provide as much descriptive detail on the exhibit label as possible**
- **Remind medical staff to avoid cutting through bullet holes in clothing**
- **Consider swabbing for gunshot residue (GSR)**

Victims of shootings are potentially a rich source of forensic evidence and without hindering/delaying any urgent medical attention, the following should be considered:

- Comprehensive photographs/video of victim
- Pre-transfusion blood sample. Medical practitioners are advised that pre-transfusion samples must only be taken by those who are “*appropriately trained in taking blood forensically*” so that continuity of evidence can be ensured. If no such person is readily available they are told to delegate the responsibility to the police to provide an appropriately trained forensic medical examiner (FME) (Clinical Effectiveness Committee 2011).
- Contact trace material, for example:

- Loose debris (textile fibres, hairs, fragments of paint, glass, metal, bullet fragments, shot pellets, shotgun wadding)
- Powders (Gun-shot residue (GSR), CS spray)
- Liquids/Stains (noxious liquids, sprays, body materials such as blood and saliva)

Much of the above will be achieved through the seizure of the victim's clothing. If the victim is able to undress themselves, then this should be done with them standing on a clean sheet of brown paper to ensure that anything that falls from them is captured. The sheet of paper should be retained, folded inwards, bagged, sealed and exhibited separately.

Each item of clothing should be placed into a separate brown paper bag and labelled with a detailed description of the item. Best practice prescribes that it is photographed/videoed as it is bagged to prevent unnecessary interference later on, as investigators try to determine exactly what is inside. Brown paper bags which have a clear window section also provide the additional benefit of allowing investigators to get a better appreciation of the exhibit (for example the exact colour / pattern etc.) and detail which may otherwise be difficult to record in descriptive terms on the exhibit label.

Where a victim receives treatment at a scene or hospital, medical practitioners are advised to avoid cutting through damaged parts of clothing such as bullet holes – but officers should be mindful of this and politely offer a reminder if necessary.

In addition to the usual major crime scene samples that an SIO may require (many listed above) consideration should also be given to swabbing / taking samples for gunshot residue. This might include swabbing the victim's hands, face, and securing hair comings. Consideration should also be given, subject to medical approval, to swabbing around the site of any gunshot injury. The benefit of doing this may be arguable, however there are some that suggest that it might allow a forensic expert to better interpret the scene and could for example, subject to limitations, provide evidence in terms of the proximity of the shooter to the victim, or in the case suspected self-inflicted injury, offer some additional corroboration.

1.4. Hospitals reporting gunshot injuries and disclosing patient information

Key Points

- **The General Medical Council requires hospitals to notify police promptly of firearm related injury admissions**

- **Hospitals will not provide personal patient details unless their public interest criterion is met (i.e. immediate disclosure is required to 1. prevent death or really serious harm, or, 2. help prevent, detect or prosecute serious crime)**
- **Hospital staff will notify the patient of any disclosure they make**
- **If the public interest test is not met, hospitals will not disclose further information without a court order / warrant**
- **Police will not be allowed access to patients if treatment or recovery will be compromised**
- **Medical staff will not allow police access to patients without the patients consent. If the police set out to medical staff any consequences of a patient not giving consent to see them, the staff will bring this to the attention of the patient.**
- **If consent is not forthcoming from the patient, police will not be provided access to them.**

Guidance from the General Medical Council (GMC) (2009) sets out the circumstances in which medical staff should inform the police of persons presenting with firearm related injuries.

The guidance advises that medical staff should inform the police promptly so that threat, risk, and harm can be assessed in respect of the patient, those treating him/her, other staff, visitors, and the hospital site itself. It also reinforces the fact that early notification will allow the police to assess the risk of another attack at or near to the scene of the original shooting.

Medical staff are advised that if they are engaged in the treatment of the patient then the responsibility to notify the police should be delegated to another person to ensure early notification.

Medical staff are advised to make a “professional judgement” in relation to disclosing personal information and decide whether it is in the public interest to do so. The criterion for public interest is that it is immediate and:

- Not disclosing would put the patient or others at risk of death or really serious harm, and/or
- Disclosure is likely to help in the prevention, detection or prosecution of a serious crime

Medical staff are advised to seek consent, even if the public interest test is met, and furthermore, inform the patient if a disclosure has been made in the public interest.

If there is no immediate public interest to disclose, then medical staff will not provide further information without a court order / warrant.

1.4.1. Access to a gunshot victim in hospital (not under arrest).

Medical staff will not allow police access to the patient if it will hamper treatment or compromise their recovery. Otherwise they will seek the patient's consent before allowing police access to speak to them. If consent is not given, medical staff are advised to explain what the consequences may be of not doing so. Police should advise medical staff, before they seek consent, of what any such consequences might be. GMC guidance makes it very clear that, should consent not be forthcoming, medical staff and police must abide by the patient's decision.

2. Deceased Victims and Autopsy Consideration

Key points

- The role of the forensic pathologist in the post mortem of a firearms related victim is like that of other forensic post mortems; generally, to establish cause of death, to document and interpret injuries, to document and interpret natural disease, obtaining material for appropriate specialist analysis, such as toxicology, and other areas such as the general demographics of the deceased.
- There must be a radiological (e.g. x-ray) examination prior to the autopsy.
- Autopsy examinations should take place at a mortuary with suitable radiological facilities.
- The purpose of radiological examination is principally to identify and aid recovery of projectiles within the body. It may also provide additional information on wound tracks and bone injury.
- If a patient initially survived and was subject of radiological examination prior to death, a full radiological examination must still be completed prior to the autopsy, because the 'in life' examination is unlikely to have included all necessary parts of the body, such as limbs. Projectiles may have travelled to outer parts of the body via blood vessels.

- There are different methods of conducting a radiological 'skeletal survey' using conventional plain film or by CT scans. The SIO should consult with the pathologist beforehand to identify, in the circumstances, which is preferred.
- A consultant radiologist will almost certainly be required to assist the forensic pathologist in the radiology. This should be borne in mind when making arrangements with the hospital.
- Whether or not the body is removed from the body bag prior to a radiological examination is a matter for discussion on a case by case basis between the pathologist, the consultant radiographer and the SIO.
- CT scanning is undertaken with the body in the body bag.
- It is preferred that trace sampling, particularly for Gunshot residue, takes place at the scene or the location of the radiological facilities.
- Sometimes, radiological re-examination is required where a projectile has not readily been identified, making it more important to utilise a mortuary with such facilities available.
- A forensic firearms expert should attend firearm related autopsies. From a forensic pathologist's viewpoint, they provide valuable assistance.
- The pre-autopsy briefing should follow the format of other forensic post mortem examinations. In addition however, the pathologist will require information on recovered firearms, intelligence surrounding the victim or suspect as this will assist in a strategy for the post-mortem, including evidence recovery.
- Pathologists are increasingly encountering prior firearm injury at autopsies, this may mean that there are pre-existing projectiles within the deceased's body. Such information, if known, is useful to the pathologist. Correlation with prior radiological examination is also of significant benefit.
- Pathologists prefer gunshot residue samples to be taken from the deceased at the scene. They do also however recommend bagging of hands to preserve trace evidence if sampling cannot be done prior to a post-mortem examination.
- All rifled projectiles should be removed from the body during the post-mortem examination.
- Only a sample of shotgun pellets are usually required to be removed from the body during the post-mortem examination.
- Projectiles should be removed with plastic forceps to avoid damage due to their malleable nature. Because not all mortuaries have plastic forceps, police

crime scene investigators should ensure they have them available in their mortuary kits, and bring them to the mortuary for the examination.

- **Following the autopsy examination the pathologist will provide a cause of death. In addition they will provide an overview of number and general direction of discharges and some limited indication of range (e.g. close contact, or distant). The pathologist may be able to indicate self or third-party infliction.**

The forensic pathologist's role in conducting an autopsy examination on a suspicious death will include generally:

- Establishing a Cause of Death.
- Documenting and interpreting injuries.
- Documenting and interpreting natural disease.
- Obtaining material for appropriate specialist analysis, such as toxicology.
- Other areas, such as the general demographics of deceased.

The role in a ballistics related fatality remain the same albeit important differences arise from other suspicious deaths.

2.1. Pre-Autopsy Radiology

Radiological investigation prior to the autopsy examination is considered mandatory and this is incorporated into most regulatory documentation, such as the "Code of practice and performance standards for forensic pathology in England, Wales and Northern Ireland". Similar documentation exists for practitioners in Scotland. Autopsy examination should therefore utilise a mortuary with suitable radiological facilities.

The purpose of the radiological assessment is principally to identify within the body projectiles, and also to facilitate their recovery. Additional information may or may not be identifiable, such as wound tracks and the presence of concomitant bony injury. If the deceased survived initially to die later in hospital, 'in life' radiology alone may not be adequate as it will often not capture areas of the body, particularly the limbs. It is not unheard of for projectiles to enter and travel down blood vessels and end up at the extreme parts of limbs.

A radiological 'skeletal survey' may be conducted either by conventional plain film or by CT (computed tomography) scans. In general conventional film is being replaced by CT scans. Conventional plain film has disadvantages over CT scans. Areas of film projections may unintentionally not overlap and as a result relevant body areas may not have been included in the survey. Plain film radiographs also provide a two-dimensional viewpoint. An identified projectile may be at any point from the front to back of the body part. Side view plain films may assist but this is not guaranteed. Plain films have an advantage over CT scans as that all forensic pathologists will be able to identify a radio-opaque projectile on a film whereas only a limited number of forensic pathologists (at this stage) have experience of reviewing CT scans. As a result a consultant radiologist will almost certainly be required to assist the forensic pathologist in the radiology and thus identifying the projectile and its location.

Whether or not the body is removed from the body bag prior to the radiological investigation is a matter for case by case discussion. With plain film radiographs removal of the body from the body bag may be required to facilitate adequate radiography, but this is not an inevitable consequence. Where required it is advisable that any trace sampling, particularly gunshot residue, is considered beforehand and undertaken at the scene or at the location of the radiology facilities. CT scanning is undertaken in a body bag.

Even with good initial radiological investigations and good autopsy technique a projectile may not be readily identifiable and radiological re-investigation will be required. A number of approaches can be utilised, but the use of a mortuary with direct access to radiology facilities is therefore recommended.

2.2. Forensic Firearms Expert

It is best practice for the autopsy examination to be conducted in the presence of an expert in firearms. From a forensic pathologist's viewpoint they provide valuable assistance.

2.3. Pre-Autopsy Briefing

The briefing should follow that of a standard format of other forensic post-mortem examinations, although clearly it should be tailored to the circumstances of the death. Information regarding recovered firearms (or intelligence surrounding the victim or purported offender) will assist in a strategy for the post-mortem, including evidence recovery. Increasingly prior firearm injury is encountered at the autopsy examination and it is useful to have some indication of this, if known. It is not uncommon for projectiles to remain in the

body from these prior incidents. In these circumstances correlation with prior radiological examination is of significant benefit.

2.4. Gunshot Residue Sampling

From a pathologist's perspective, gunshot residue sampling can be undertaken at the scene in the context of other samples taken at that time. Consultation with the instructed ballistics expert may be appropriate. Bagging of the hands may preserve trace evidence.

2.5. Recovery of Projectiles

In general all rifled projectiles should be recovered from the body whereas only a sample of the shotgun pellets are usually required. The projectiles should be recovered with plastic forceps in order to avoid damage due to its malleable nature. Not all mortuaries will have plastic forceps easily at hand and Scene of Crime Officers should ensure that they are brought to the mortuary.

2.6. Interpretation

Following the conclusion of the autopsy examination (and review of the appropriate ancillary investigations) the forensic pathologist will collate the information and provide a cause of death. Given the circumstances of a ballistics death this is likely to relate to the firearm's discharge. However, concomitant injuries or natural disease may in itself cause death or contribute to it.

The pathologist will provide an overview of the number and general direction of the discharges. A pathological indication of range (for example, close contact, or distant range) can be provided but precise distance interpretation is for the ballistics expert in the context of the recovered firearms.

The pathologist may be able to provide some interpretation on the likelihood of self infliction or third-party infliction. For example, the presence of classical contemporaneous self harm marks may raise the prospect of self infliction whereas evidence of concomitant blunt force or sharp force assault equally may raise the prospect of third-party infliction. The feasibility of the deceased facilitating the self discharge can be progressed but is heavily reliant on the ballistics expert.

APP** Link to ***Investigation***

APP** Link to ***Critical incident management***

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