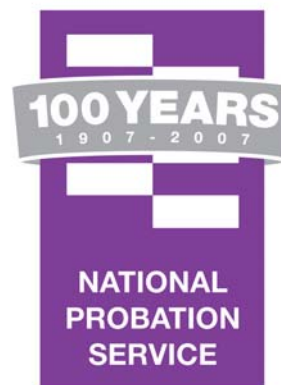


# Probation Circular



## PC40/2007 – DEATHS OF APPROVED PREMISES RESIDENTS – INVESTIGATIONS BY THE PRISONS AND PROBATION OMBUDSMAN (PPO)

**IMPLEMENTATION DATE:** 28 December 2007

**EXPIRY DATE:** March 2009

**TO:** Chairs of Probation Boards, Chief Officers of Probation, Secretaries of Probation Boards

**CC:** Board Treasurers, Improvement and Development Managers

**AUTHORISED BY:** Gordon Davison, Acting Head of Public Protection Unit

**ATTACHED:** Annex A: Notification proforma

Annex B: Key processes – guidance

Annex C: Key processes – flowchart

Annex D: PPO Disclosure Guidance

Annex E: Equality Impact Assessment Form

### RELEVANT PREVIOUS PROBATION CIRCULARS

PC23/2007, PC20/2007, PC35/2006, PC40/2004, PC2/2004, PC18/2004

### CONTACT FOR ENQUIRIES

[paul.douglas@justice.gsi.gov.uk](mailto:paul.douglas@justice.gsi.gov.uk) or 020 7217 0773

[mark.rollason2@homeoffice.gsi.gov.uk](mailto:mark.rollason2@homeoffice.gsi.gov.uk) or 020 7217 5216

## PURPOSE

This circular replaces PC18/2004, and provides details about the responsibility of the Prisons and Probation Ombudsman (PPO) to investigate all deaths of Approved Premises' residents.

## ACTION

Chief Officers and Chairs of Voluntary Managed Committees are asked to bring this guidance to the attention of all staff who need to be aware of it, e.g. Approved Premises Managers, Deputies and staff, Offender Managers, etc. Please could all staff note the contents of this circular. Please note that these procedures involve Offender Managers, staff who deliver programmes and staff in partner agencies etc, and not just Approved Premises staff.

## SUMMARY

Since 1 April 2004, the PPO has investigated all deaths of Approved Premises' residents. This revision updates contact details at the PPO and PPU (NOMS).

## Background

- 1 In 2004, Ministers decided that all deaths of Approved Premises' (AP) residents would be investigated by the Prisons and Probation Ombudsman (PPO). This strengthening of deaths investigations brings more independence into our current processes, and thus provides additional reassurance to bereaved families, and will assist all of us in making improvements to operational procedures. This circular is a revised version of PC18/2004 (itself a follow-up to PC2/2004), and provides detail on how the arrangements work in practice.
- 2 The involvement of the PPO brings further rigour to our processes for investigating deaths of AP residents, and all staff should be aware that PPO Investigators will not confine their enquiries simply to the AP. The Investigators will wish to collate as much information as possible, and will therefore wish to know, for example, about what supervision a deceased resident has had from probation staff who are not employed at the AP, e.g. the Offender Manager, and about activities that a resident has attended outside of the AP, as well as medical appointments, etc.

## Notification

- 3 If a death of a resident is discovered at the AP or if your AP is notified of the death of a resident elsewhere, the PPO must be informed, as soon as practicable, but certainly within 24 hours of that discovery / notification, by paging the Duty PPO officer as follows:
  - Telephone the following number: **07654 382649**
  - The operator will say: "Welcome to 02 paging. Please enter your numeric message followed by hash # or hold for an operator"
  - You should then simply key in the number of the telephone you want the person you are paging to call you back on. Please remember to include the STD Code. When you have done that press the hash # key at the bottom right hand corner of the telephone key pad.
  - The operator will then say " Paging request accepted"
  - You can then hang up.
- 4 On receipt of the message, the PPO Duty Officer will call the number provided and ask for brief details of the incident so that an Investigator can be allocated and the investigation launched. The PPO's target for opening an investigation is within three working days.
- 5 In the case of a Probation Board-managed AP, this initial notification can be done by an SPO, but it is for the local ACO with responsibility for APs to ensure that this has been done.
- 6 In the case of a death of a resident of a Voluntary Managed-Approved Premises (VMAP), different arrangements will need to apply. Because the Voluntary Management Committees (VMCs) are responsible for the buildings and are the employers of the staff of the VMAP, it will be necessary to designate either the Manager, or a member of the VMC, as the person who has the responsibility of notifying the PPO (and PPU) of the death. Depending on what local arrangements have been agreed and set up, it may be in order for the local ACO to do the initial

notification.

7. It is important to note that PPU also need to continue to be notified when a death of an AP resident occurs. Please ensure that notification is made within 24 hours of the death occurring, or on the next working day, to:

Approved Premises Team  
Public Protection Unit (PPU)  
National Probation Service (NPS)  
National Offender Management Unit (NOMS)  
G21, Abell House  
John Islip Street  
London  
SW1P 4LH

**Tel:** 020 7217 0773 **Email:** [approvedpremises@homeoffice.gsi.gov.uk](mailto:approvedpremises@homeoffice.gsi.gov.uk)

8. PPU need to have this information so as to be able to notify Ministers, the Chief Executive of the National Offender Management Service (NOMS), the Director General of the National Probation Service for England and Wales and others who have a need to know. We also need to be able to maintain records on deaths and produce statistics periodically. Please find attached at **Annex A**, a proforma to be used for notifying deaths of AP residents to the PPU.

#### Information for the Ombudsman Investigator

9. **Annex B** describes the procedures and what the requirements for initial information are likely to be. Please note that the PPO already has copies of the AP Handbook, National Standards, AP Regulations and copies of relevant PCs.
10. **Annex C** sets out in flowchart form how the main processes should work.

#### Family Liaison Officers (FLOs)

11. The PPO have a number of Family Liaison Officers. The PPO will routinely try to contact the next of kin for all deaths of AP residents, to allow the family of the deceased to make an input into the enquiry, and to involve them as much as they wish to be in the process.

#### Support for Staff

12. We know that any death of a resident is always a traumatic event, and it is important that appropriate support is available for staff. Investigations will involve, amongst other things, staff being interviewed by a PPO Investigator, rather than a line manager from their probation area.
13. The PPO has advised us that it is likely that their investigators will almost always tape record their interviews with staff and others. This ensures that staff and residents etc are not misquoted in any way, and that nothing can be attributed to them that was not actually said during the interview. The taped interviews are

transcribed and sent to interviewees to check and sign. The transcripts are then attached to the report when it is sent to the family, probation area and coroner.

#### **Disclosure & Publications of Reports (Annex D)**

- 14 The PPO may decide to disclose documents during the course of the investigation, before the report has been drafted. For example, it may be that early disclosure of documents to the family will allow them to raise relevant issues during the course of the investigation. If there is any doubt as to whether documents should be disclosed, the views of the Service (or individuals) will be sought and considered. However, the PPO is not bound by those views.
- 15 Draft copies of PPO reports will be made available in advance so that probation areas and VMCs will have 28 days in which they can check these for any factual inaccuracies and make any final comments. Draft copies will also be sent to the family of the deceased, as will feedback from Areas. The PPO's final reports (anonymised in respect of the deceased) are published on the PPO website after the inquest has taken place.

#### **Recommendations made by the Ombudsman**

- 16 The involvement of the independent PPO in the process of investigating the deaths of all AP residents has raised expectations significantly. There is therefore a duty on everyone involved to respond quickly and appropriately to recommendations made in reports by the PPO.

#### **Conclusion**

- 17 Although we have attempted to set out in this PC in as much detail as possible how the procedures should work, there will no doubt be some aspects which have not been covered. Please contact PPU for further advice as necessary. For general advice from the PPO, the contact details are:

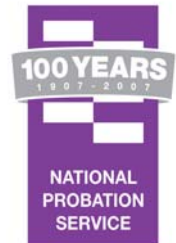
Prisons and Probation Ombudsman  
Ashley House  
2 Monck Street  
London  
SW1P 2BQ

**Tel:** 020 7035 2876 or 0845 010 7938 (lo-call)

**Fax:** 020 7035 2860

**Email:** [mail@ppo.gsi.gov.uk](mailto:mail@ppo.gsi.gov.uk)

**Website:** [www.ppo.gov.uk](http://www.ppo.gov.uk)



**Annex A**

**NOTIFICATION TO PUBLIC PROTECTION UNIT (PPU)**

<b>NAME OF RESIDENT</b>	
<b>APPROVED PREMISES &amp; PROBATION AREA</b>	
<b>DATE OF DEATH</b>	
<b>GENDER</b>	
<b>ETHNIC ORIGIN</b>	
<b>DATE OF BIRTH</b>	
<b>STATUS (Bailee, Licensee, ROTL, etc)</b>	
<b>OFFENCE / ALLEGED OFFENCE</b>	
<b>DATE &amp; TIME WHEN PPO WAS NOTIFIED</b>	
<b>BRIEF CIRCUMSTANCES OF DEATH</b>	
<b>ANY MEDIA INTEREST</b>	
<b>NAME &amp; CONTACT NUMBER OF THE ACO WITH RESPONSIBILITY FOR THE APPROVED PREMISES</b>	
<b>NAME &amp; CONTACT NUMBER OF THE OFFENDER MANAGER WITH RESPONSIBILITY FOR THE DECEASED RESIDENT</b>	
<b>NAME OF PERSON COMPLETING THIS FORM</b>	

Approved Premises Team, Public Protection Unit  
National Probation Service / National Offender Management Service  
Ministry of Justice

PLEASE EMAIL COMPLETED FORM TO: [approvedpremises@homeoffice.gsi.gov.uk](mailto:approvedpremises@homeoffice.gsi.gov.uk)

## Annex B

### **ADVISORY NOTE ON KEY PROCESSES AND GOOD PRACTICE IN RESPECT OF PRISONS & PROBATION OMBUDSMAN (PPO) ENQUIRIES INTO THE DEATH OF A RESIDENT OF AN APPROVED PREMISES (AP)**

- 1 Advise the Prisons and Probation Ombudsman (PPO) of the fatality of the resident of an AP (wherever it occurs) as soon as practicable, but always within 24 hours, by using the pager: **07654 382649**  
(NB – always leave the full STD code and telephone number of the AP)
- 2 Advise the Approved Premises Team, Public Protection Unit (PPU), National Offender Management Service (NOMS), by email to: [approvedpremises@homeoffice.qsi.gov.uk](mailto:approvedpremises@homeoffice.qsi.gov.uk) using the pro-forma at Annex A to this PC. If you wish to discuss the case with a member of the AP Team, please telephone **020 7217 0773**.
- 3 Secure CCTV tapes and secure print out of electronic case file or photocopy of written case file to include assessments, plans and contact entries.
- 4 As soon as the name of the PPO Investigator is known, advise them of the location of the AP by emailing a location map with travel details, full postal address and all relevant contact numbers. The PPO will normally undertake making all the arrangements for travel and overnight accommodation although advice might be sought as to the most convenient or recommended hotels.
- 5 To accompany the above information, please further advise the PPO on the name and the addresses of the Chief Officer and Chair of the Probation Board and the name, office address and contact details for the Assistant Chief Officer for the Approved Premises and, where relevant, the contact details for the Chair of the Committee for Voluntary-Managed Approved Premises.
- 6 Please arrange to have available for the arrival of the Investigator (as best as possible within the resources of the building) an office or private space, if possible with telephone, for the purposes of interviews, reading of case information and the writing of notes.
- 7 Commence the creation of a file for the Investigator to include a copy of the information requested above in point 3. Documents that the PPO Investigator will require include the following:
  - a building plan - either a copy of architect's drawings etc or simplified hand-drawn diagram
  - the AP log book with photocopies of the relevant pages
  - a sample copy of hostel house rules together with any other house requirements or information routinely issued to residents
  - sample copies of the referral form and induction papers
  - copies of policies, procedures or practice guidance, including the Sudden Death Strategy for the Area / Region

- any health and safety assessments, reports or inspection details, ie relevant to the period of the resident's stay at the AP
- the Daily Register for the day on which the resident died and a list of residents or photocopy of those listed on the register
- a staff list to include roles / job titles,
- a list of staff who were on duty on the day of the death and the times they were on duty
- details of the daily routine / regime
- a note of the on-site medical services to include GP and / or CPN arrangements
- information about the principle partner agencies who deliver services to residents, eg mental health, drug and alcohol services

8 With regard to the resident, the following should also be included in the materials immediately available for the Investigator:

- the full AP case file to contain the licence or Court Order, referral papers (the referral registration book / print out of the computer record), OASys assessment, and supervision plans, risk of harm assessment and risk management plan, risk of self-harm and suicide assessment and management plan, admission / induction papers and any other documents signed by the resident, minutes of MAPPP meetings, and other meetings of significance.
- details of the Offender Manager (OM) and contact details – please make a specific note if the OM is 'out of area'. The OM should plan maximum availability during the period of the investigation and have case records and the case file available.
- the case-contact records including the OM's and AP records if they are not integrated. (Print-out records if held electronically). The contact record copy or print out made at the first available opportunity by a manager following the notification of the fatality. This document should be clearly identified along with the date and time that it was obtained.
- medication record. Please note (confirm) if no prescribed medication was held at the AP.
- details of the next of kin.
- previous convictions, pre-sentence and parole reports.
- list of property recovered from the deceased's room following discovery or notification of the death if the police have agreed to removal of personal items for safe storage.

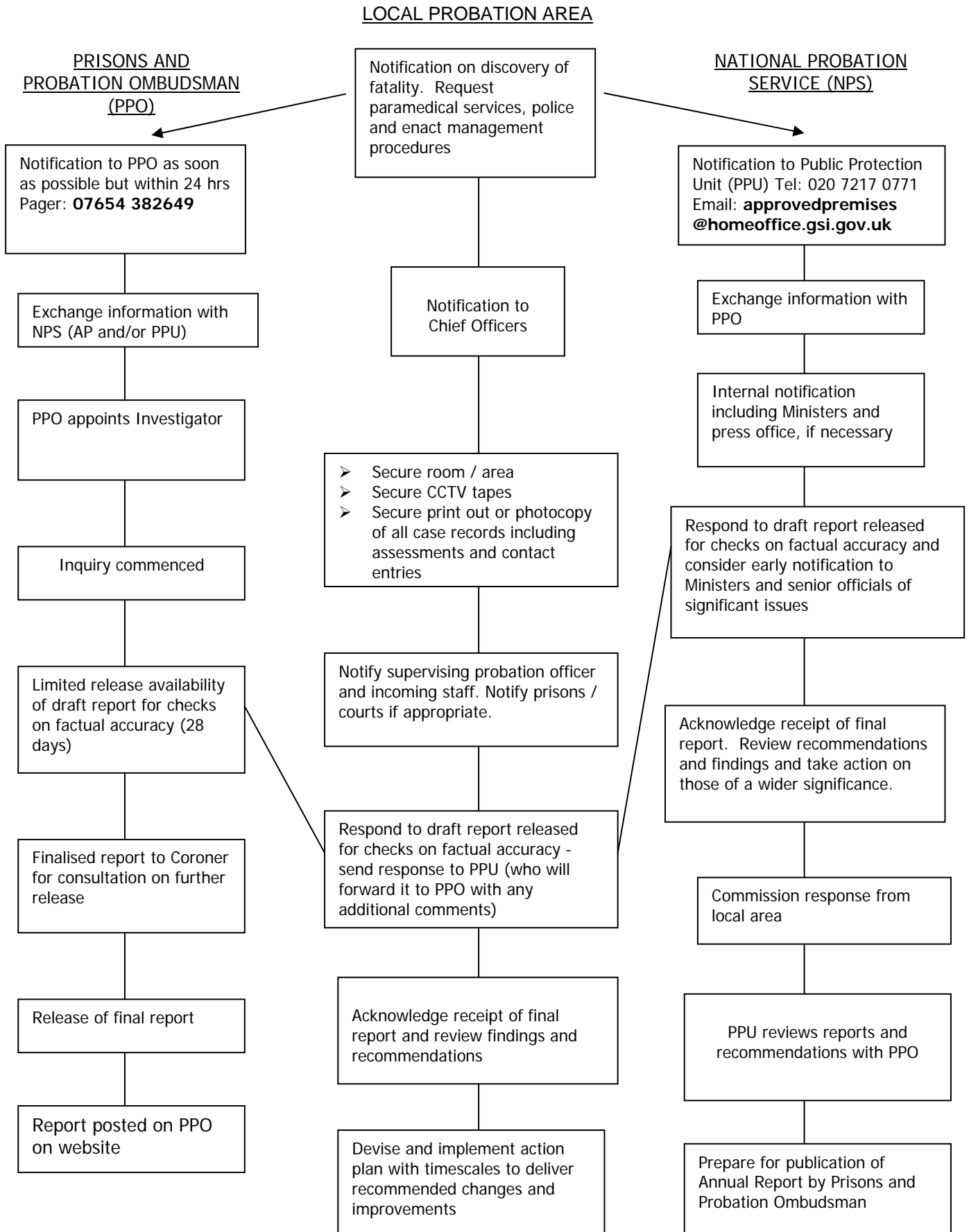
9 Please give consideration to:

- advising staff and residents of the arrangements
- the initial welcome and familiarisation arrangements for the Investigator including a brief tour of the premises and a meeting with the Manager and Deputy Manager
- access to refreshments
- access to staff to explain any initial query – use of acronyms in records, etc
- access to a photocopier
- the issue of keys / swipe cards etc for the Investigator
- issue of personal alarm to Investigator
- briefing on personal safety, fire and evacuation procedures

10 In the event of further advice or information being required please contact the PPO directly or the Approved Premises Team in the Public Protection Unit.

**Annex C**

**PROCESS RESPONSE TO FATALITY**



## **PRISONS & PROBATION OMBUDSMAN GUIDANCE ON DISCLOSURE**

### **1. INTRODUCTION**

- 1.1 At the heart of the Prisons and Probation Ombudsman's work on fatal incidents is a commitment to full, fair, open and transparent investigations. This is essential to meet the aims of the Ombudsman's investigation, as set out in his terms of reference. Of particular relevance is the aim of assisting the inquest in meeting the State's obligations under Article 2 of the European Convention on Human Rights. This includes enabling the family to participate fully in the inquest, and ensuring that the full facts are brought to light. It is also one of the Ombudsman's aims to provide explanations and insight for bereaved relatives.
- 1.2 The question of what information should be disclosed to whom, and when, has to be set against the background of these fundamental principles. The Ombudsman's presumption is that disclosure should occur as fully and as early as his powers and the law allows.

### **2. DISCLOSURE POWERS**

- 2.1 Ombudsman's powers of disclosure are set out in his terms of reference for the investigation of deaths.

“Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the NHS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.”

- 2.2 This paper sets out guidance on the Ombudsman's powers of disclosure. Drafts of the document were sent to a range of interested parties and the Ombudsman has carefully considered the points raised and made a number of improvements as a consequence. We are grateful to those who offered comments and would welcome further contributions as our working practices develop. Some of the comments we received were more relevant to other policies that we are developing and will be taken forward separately.
- 2.3 In line with our values of openness and accountability, this document on disclosure policy will be published on the Ombudsman's website.

### **3. WHO DECIDES ON DISCLOSURE**

- 3.1 It is for the Ombudsman, or his staff on his behalf, to decide what information from the investigation should be disclosed, to whom, and when.
- 3.2 Before the inquest, the Ombudsman should consult the Coroner on disclosure. But the final decision on disclosure of information from the investigation is for the Ombudsman. It is primarily the legal responsibility of the Ombudsman, rather than the Coroner, to satisfy the Article 2 investigative obligation by making pre-inquest disclosure.

- 3.3 Coroners have their own obligations about disclosure of documents that are available to them, for example from their own investigation or from the police.

## 4. WHAT CAN BE DISCLOSED

### Relevant information

- 4.1 The Ombudsman can only lawfully disclose information that is relevant to the investigation. So before disclosing each piece of information, the investigator must be sure that all or part of it is relevant to the investigation, and the aims the investigation is seeking to achieve. Only the relevant parts can be disclosed. For example, if a document contains a prison officer's name and address, it may be that his or her name is relevant, but not the address. In this case, the address should be redacted before the document is released.
- 4.2 All the information in an investigation report, and its annexes, should be relevant to the investigation. When drafting reports and deciding on the inclusion of annexes, investigators must always apply the test of relevance. If a piece of information or a document is not relevant, it must not be included. It follows, then, that investigation reports and annexes will almost always be subject to full disclosure, unless any of the information falls into the exemptions set out below.

### Exemptions to disclosure

- 4.3 Once the investigator is satisfied that the information is relevant to the investigation, they must then go on to consider whether there is an exceptional reason for it being exempt from disclosure. There are two exemption tests - whether the disclosure of third party information would be unlawful, and whether disclosure of any information would be against the public interest.

#### **Would disclosure of third party information be unlawful?**

- 4.3.1 Investigators must consider particularly carefully the question of whether third party information (i.e. information about an identifiable third party) should be disclosed, or whether disclosure would be unlawful. The relevant legal tests are set out below.

#### ***Data Protection Act 1998 and Article 8 of the European Convention on Human Rights***

- 4.3.1.1 The disclosure of ***irrelevant*** third party information will almost always be unlawful under the terms of the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights. It is therefore absolutely essential that the investigator is satisfied that any third party information passes the test of relevance to the investigation.
- 4.3.1.2 If disclosure of relevant third party information is necessary to fulfil the aims of the investigation, which includes the aim of enabling the family to participate meaningfully in the inquest, then disclosure of the information is unlikely to be a breach of the Data Protection Act. Under Article 8, disclosure of third party information can be made in order to protect the rights and freedoms of others. This includes the right to a proper Article 2 investigation. So disclosure of relevant information is also unlikely to be a breach of Article 8. But the extent of information disclosed must be proportionate. The more sensitive the third party information, the more care needs to be taken that full disclosure is essential to meet the Article 2 investigative obligation. For example, information that a third party has HIV and is a prostitute would need to be very relevant before it should be disclosed. If it seems that

disclosure of the information in full may not be proportionate, investigators should consider whether documents could be anonymised or redacted without compromising the aims of the investigation.

- 4.3.1.3 Once an investigator has decided that relevant information can lawfully be disclosed, it is not necessary to get the consent of the third party to the release of the information. However, it would be courteous to let them know that the information is to be disclosed (see section 6 below).

#### ***Common law of confidentiality***

- 4.3.2.1 The Ombudsman may owe a duty of confidentiality in relation to information that is provided to him in confidence.
- 4.3.2.2 However, the fact that someone says that information is provided in confidence does not necessarily make it so. For example, information already available from another source, or normally available from the inspection of records, cannot be made confidential by labelling it so. It is necessary to consider the content of the information in order to decide whether it has genuinely been provided in confidence.
- 4.3.2.3 It will almost always be unlawful to disclose genuinely confidential information if it is not relevant to the investigation.
- 4.3.2.4 On the other hand, it may be unlawful **not** to disclose confidential information if it is relevant to the aims of the investigation and disclosure is necessary to meet the Article 2 investigative obligation. In these circumstances, the investigator will have to balance the duty of confidentiality against the Article 2 investigative obligation, and try to find a compromise if appropriate. For example, it may be possible to meet both the confidentiality and the Article 2 duties by providing the information in a summary, anonymous or redacted form.

#### ***Articles 2 and 3 of the European Convention on Human Rights***

- 4.3.3.1 There may be circumstances where the disclosure of relevant third party information would put a third party's life or safety at risk, and therefore breach their own right to life under Article 2 or their rights under Article 3. There might, then, be a conflict between the Article 2 investigative obligation and the Article 2 or Article 3 rights of the third party. If there is a real risk of breaching a third party's Article 2 or Article 3 rights, then the third party information should not be disclosed. But consideration should be given to whether documents can be anonymised or redacted to avoid compromising the Article 2 investigative obligation.

#### **Would disclosure be against the public interest?**

- 4.3.2 Disclosure can lawfully be withheld when it would be against the public interest. The investigator must consider whether, for example, disclosure would be against the interests of national security, likely to prejudice prison security, or likely to prejudice the administration of justice. Disclosure of information in these circumstances would not necessarily be unlawful, but it may be lawfully withheld.
- 4.3.3 Care needs to be taken with security information reports where disclosure might, for example, prejudice future collection of information, or endanger sources of information. There may be grounds for redacting the reports, summarising them in general terms in the Ombudsman's report, or withholding them.

- 4.3.4 It will be rare for documents to be withheld entirely, without providing even an outline of the information in the documents. If documents are being withheld entirely, the investigator should normally confirm that the documents exist, unless there is a good public interest reason not to do so.
- 4.3.5 There are specific issues in relation to **medical records** and public interest questions. The family of the deceased will almost certainly have a right under the Access to Health Records Act 1990 to the medical records of a family member who has died, and public interest questions do not have to be considered. This applies irrespective of whether or not the information is relevant to the aims of the Ombudsman's investigation.
- 4.3.6 But in relation to medical information about a third party, public interest questions do come into play. Medical confidentiality exists to protect both the individual and the broader public interest in the provision of a confidential medical service. So disclosure of relevant third party medical records can lawfully be withheld when it is considered to be in the public interest. Medical confidentiality should only be breached where it is really necessary and proportionate to do so in the public interest, or to protect the public.
- 4.3.7 The **Freedom of Information Act 2000** stands separately from the tests set out above. The Act allows anyone to request copies of any recorded information held by the Ombudsman, and there is a presumption in favour of disclosure. However, there is an absolute exemption from the duty to disclose personal information which is covered by the subject access provisions of the Data Protection Act, and information provided in confidence where there is an actionable breach of confidence. There are also some qualified exemptions, where the public interest has to be balanced against the duty to disclose. This applies to matters of national security, and to investigations conducted by public bodies.
- 4.3.8 It is important to bear in mind that general policy and procedure documents (those that do not include personal information, or security information that it is not in the public interest to disclose) are likely to have to be made available to anyone who asks for them.
- 4.3.9 Investigators should first consider whether any information requested should be released on the basis of the Ombudsman's powers of disclosure. If the decision is that the information cannot be disclosed under the Ombudsman's powers, then it will be necessary to go on and consider whether it can be disclosed under the Freedom of Information Act. There is separate guidance for the Prisons and Probation Ombudsman's office on disclosure of information under the Freedom of Information Act.

## 5. TO WHOM SHOULD INFORMATION BE DISCLOSED?

- 5.1 The Ombudsman may disclose information to anyone whom he considers requires it in order to meet the aims of his investigation. This will include the organisations under investigation, and any specific individuals who may be subject to criticism. It will be particularly important in the pre-inquest phase to disclose information to the family of the deceased, their personal representatives, and anyone else who will be involved in the inquest, so that they can properly prepare for it. In some circumstances, it may be relevant to disclose information to prisoners or approved premises residents, for example, where there is specific comment or criticism of their actions.

- 5.2 The Ombudsman would want to disclose information to anyone the Coroner would consider an 'interested person' at the inquest. But he is not restricted by the Coroner's decision as to who is an 'interested person'. It is for the Ombudsman to decide to whom information should be disclosed in order to meet the aims of his investigation.
- 5.3 It will not automatically be the case that disclosure should be made to the trade unions. The investigator will need to decide whether disclosure is necessary to meet the aims of the investigation. For example, if a prison or probation officer is being represented by the trade union (which will often be the case), then it is likely that disclosure would be appropriate. But if the trade union is asking for a copy of the report for its own purposes, then disclosure may not be appropriate.
- 5.4 For the purposes of the investigation, the Ombudsman may disclose information to specialist advisers, and other bodies conducting related investigations, for example, the NHS or Social Services.

## **6. WHEN SHOULD INFORMATION BE DISCLOSED?**

### **During the course of the investigation**

- 6.1 During the course of the investigation, the Ombudsman will have access to a number of documents. Most of these will be records from the relevant service, but some will be from other sources, such as the police (for example police statements, custody records). Documents may be disclosed during the course of the investigation, but before the report has been drafted, as long as the tests set out above are met. For example, it may be that early disclosure of documents to the family allows them to raise relevant issues during the course of the investigation, or provides them with a full opportunity to prepare for the inquest.
- 6.2 If there is any doubt as to whether the documents should be disclosed, the views of the relevant organisations or individuals must be sought. These views should be carefully considered, but the Ombudsman is not bound by them. At the end of the day, the decision on disclosure remains a matter for him. However, investigators should make sure that those involved are told of the decision on disclosure, and the reasons for it.

### **When the report has been drafted**

- 6.3 Before sending out the draft report, investigators should consult the Coroner about disclosure. It should normally be possible to do this in a telephone call. If the Coroner wants to see the draft report, a copy should be sent to him or her. If the Coroner wants to consider disclosure issues, we should press for a response within 10 working days.
- 6.4 Once the Coroner has been consulted, the draft report and appendices will normally be sent at the same time to the relevant service and to the bereaved relatives, to allow a factual check and an opportunity to respond to the draft findings. A period of 28 days will be allowed for this process.
- 6.5 However, if there are specific criticisms of individuals in the draft report, or if there are any doubts about whether information ought to be disclosed, the draft must be sent first to the service who will disclose to the individuals concerned. If in doubt, the investigator must always err on the side of prior consultation with the service.
- 6.6 The service will be given 14 days to comment on the findings or object to disclosure. The investigator will take account of these comments and decide on further disclosure. This time limit will be extended if a formal request is made and there is good reason to do so.

- 6.7 The investigator will always tell those involved of the decisions in relation to any comments or objections provided, and the reasons for them.
- 6.8 When deciding on early disclosure of the draft to the service or individuals concerned, the investigator will bear in mind the need to make sure that the family has the draft report in sufficient time to prepare for inquest, to enable them to make an informed contribution. The report should normally be sent out as soon as it is prepared. In exceptional cases, where the inquest is imminent (ie within the next 28 days), it may be necessary to waive early consultation with the service or individuals in order to ensure that the family has a fair opportunity to participate in the inquest. The investigator will need carefully to balance the circumstances of each case.
- 6.9 After the inquest, anonymised reports will be published on the website. Guidance on the process for doing this will be issued in due course.

### **When the report is finalised**

- 6.10 The finalised copy of the report should be sent to all those to whom the draft was sent. The investigator should at this point review whether there are any additional individuals or organisations to whom the report should be sent.

### **After the inquest**

- 6.11 There may be requests for additional disclosure after the inquest is over. The investigator should consider each request in the light of the guidance set out above. If there are any doubts about whether the information should be disclosed, the investigator should normally consult with the relevant parties, take account of their comments, and let them know the decision and the reasons for it.

## **7. HOW SHOULD INFORMATION BE DISCLOSED?**

- 7.1 All parties to whom disclosure is made before the inquest should be told that the information is provided in confidence. Bereaved relatives should be told that, pre inquest, the documents can only be used for the purpose of preparing for the inquest. However, once the inquest is over, it is up to bereaved relatives how they use the documents.
- 7.2 It should be made clear to all parties when the report is only a draft, and they should be warned that the final version may be changed.
- 7.3 Where individuals are criticised in the draft report, the normal way of getting the report to them is via the service concerned. The investigator should make it clear in the covering letter the specific named individuals within the service who should be given a copy of the draft report, or any relevant specified parts.
- 7.4 Bereaved relatives should always be asked if they do in fact want to see the report, and if so, how they wish to receive it. If they want to be given it personally in a meeting with the investigator, then this should be arranged via the Family Liaison Officer.
- 7.5 A record must be kept of all the documents that have been disclosed, to whom and when.

## **8. INFORMATION ABOUT DISCLOSURE ARRANGEMENTS**

- 8.1 Before individuals are asked to provide information – for example, during an interview – they should be told that the information they provide may be disclosed to relevant parties, if this is necessary to achieve the aims of the investigation. The standard notices about the

investigation and information given to interviewees explain this. However, investigators need to make sure that people giving information less formally are also aware that the information may be disclosed.

*September 2005*



<b>EQUALITY IMPACT ASSESSMENT</b>
NPS/NOMS
Performance & Improvement Directorate
Public Protection Unit

**PRELIMINARY SCREENING**

<b>Date of Screening</b>	11 12 2007
<b>Name of Policy Writer</b>	Paul Douglas
<b>Director</b>	<b>Jonathan Slater</b>

PC40/2007 – Deaths of Approved Premises Residents – Investigations by Prisons and Probation Ombudsman (PPO)		This is a <b>new</b> policy
	<b>X</b>	This is a <b>change</b> to an existing policy
		This is an <b>existing</b> policy

<b>Policy Aims, Objectives &amp; Projected Outcomes</b>	
<ul style="list-style-type: none"> <li>▪ To facilitate notification by NPS staff in Approved Premises to the Prisons &amp; Probation Ombudsman (PPO) whenever a resident dies at an Approved Premises.</li> <li>▪ This enables PPO to investigate each and every death independently and to publish reports of their findings.</li> <li>▪ Recommendations arising from such reports serve to inform policy development and improve current practise in Approved Premises (and by Offender Managers).</li> </ul>	

Will the policy have an impact on national or local people/staff?	NO
Are particular communities or groups likely to have different needs, experiences and/or attitudes in relation to the policy	NO
Are there any aspects of the policy that could contribute to equality or inequality?	NO
Could the aims of the policy be in conflict with equal opportunity, elimination of discrimination, promotion of good relations?	NO
If this is an amendment of an existing policy, was the original policy impact assessed?	NO

*If you have answered **NO** to any particular questions, please provide explanatory evidence:*

- The policy took effect in April 2004 when the PPO first began investigating deaths at Approved Premises
- This PC updates the contact details and removes the text on transitional arrangements which applied only in the first year.
- All deaths are investigated and both investigations and statistics are published.
- There is one relatively minor change: the PPO's guidance on disclosure has been added for the information of Probation Service staff. However, it does not affect the policy or procedures in any way.
- All probation areas are required to have prevention of self-harm/death strategies in place and this is also one of the 10 performance and improvement standards applicable to approved premises. Separate guidance (PCs) have been issued on both of these policies.

**"This policy was screened for impact on equalities on 11 December 2007. The following evidence [no substantive change in existing policy] has been considered. As a result of this screening, it has been decided that a full equality impact assessment is not required."**