



**Memorandum of Understanding between
the Prisons and Probation Ombudsman (PPO)
and the Coroners Society of England and Wales (CSEW)**

Introduction

1. Whilst there is a shared interest in a search for the truth concerning deaths in prison custody and immigration removal centres, and amongst the residents of approved premises, the remit of the parties is quite different. This Memorandum of Understanding (MOU) is intended to promote and continue effective working relationships between Coroners and the Prisons and Probation Ombudsman (PPO), with the object of fostering constructive cooperation and thus the wider public interest. The parties to it recognise that Coroners are independent judicial officers. The Memorandum is not binding and is not intended to create any legally enforceable rights, obligations or restrictions. It aims to promote consistency, with the intention that this will allow Coroners and the PPO the better to discharge their different and independent functions, and to use their limited resources to best effect. The Memorandum also aims to set out clearly the level of assistance that the PPO can legitimately provide to the Coroner, and the expectations that the Coroner can legitimately have of the PPO.

The role of the Prisons and Probation Ombudsman

Context

2. The PPO has three main investigative duties:
 - complaints made by prisoners, offenders under the supervision of the probation service and detainees in immigration removal centres
 - deaths of prisoners, approved premises residents and detainees due to any cause, including apparent suicides and natural causes
 - using the PPO's discretionary powers, the investigation of deaths of recently released prisoners or detainees.
3. This MOU is concerned with the second and third of these duties, the investigation of deaths, which became the PPO's responsibility in April 2004 as a result of an extension of his terms of reference by the Secretary of State.
4. The PPO office is not a statutory body and has no powers to compel the service in remit or anyone else to cooperate with its investigations. In practice, the lack of statutory independence and authority has not prevented investigators carrying out their duties. Employees of the services in remit are expected to cooperate fully with

the PPO and it would almost certainly be a breach of their terms of employment not to do so.

5. Before 2004, deaths in prison custody were investigated by a Prison Service investigator. Probation and immigration deaths were also subject to internal reviews and investigations. As well as introducing independence to the investigation and extending its scope, giving responsibility to the PPO resulted in other changes:
 - Each prison investigation includes a review of the deceased's clinical care (usually commissioned by the relevant Primary Care Trust).
 - The next of kin designated by the deceased, and any others deemed appropriate, are offered the opportunity to raise questions and issues for the investigator to consider and are sent the draft and final PPO report.
6. The Ombudsman's terms of reference (TOR) (annex 1) state that the Ombudsman will decide on the extent of the investigation required, depending on the circumstances of the death. The remit includes all relevant matters for which the service (where the death took place) is responsible or would be responsible if not contracted elsewhere. The TOR may "vary according to the circumstances of the case and may include other deaths of the same category, when a common factor is suggested".
7. The TOR say that each investigation has five aims:
 - Establish the circumstances and events surrounding the death, both regarding the management of the individual and any relevant outside factors.
 - Examine whether any change in operational matters would help prevent a recurrence.
 - Examine relevant health issues.
 - Provide explanations and insight for the bereaved relatives.
 - Assist the Coroner's inquest to fulfil article 2 of the ECHR by ensuring that the full facts are brought to light. (This does not mean that the PPO investigates on behalf of the Coroner, and Coroners may want to conduct additional inquiries through other agencies.)
8. Under his TOR the Ombudsman is required to publish his reports in anonymised form. This invariably occurs after the inquest.
9. Every death is also reported to the police and the current Memorandum of Understanding with the Association of Chief Police Officers (annex 2) states that the police investigation has primacy.¹ The PPO and the police should ensure that the Coroner is kept informed of decisions taken at strategy meetings. In practice PPO investigators make contact with the police and frequently share documentation and records of interviews. Because PPO investigators do not interview under the terms of the Police and Criminal Evidence Act, the interviews are not preceded by a caution.

¹ The Ombudsman is not certain that the concept of primacy is Article 2-compliant and may seek to change this wording.

10. The current staffing establishment for the Fatal Incidents Investigation team is:
 - Deputy Ombudsman
 - Assistant Ombudsman (4.5 whole time equivalent (WTE))
 - Senior Investigators (20 WTE)
 - Investigators (7 WTE)
 - Family Liaison Officers (4.5W WTE)
11. In order that investigators do not become over familiar with particular establishments, they all work across England and Wales and not in regional teams.
12. The number of deaths is not very predictable and the total has varied within an upper and lower range of nearly 20 per cent during the four years since 2004.

	Natural Causes	Apparently Self Inflicted	Others	Total
2004 - 05	111	92	18	221
2005 - 06	91	83	16	190
2006 - 07	90	76	20	186
2007 - 08	106	92	7	205
Total	398	343	61	802

Progress of a PPO investigation

13. Each death is reported to the PPO and is allocated to a lead investigator who retains responsibility for the case until it is closed following the inquest. The initial letters and notices include a letter to the Coroner with the name of the designated investigator. It is PPO policy that the investigation of an apparent self inflicted death is opened in person (confirmed in writing) within three working days of the notification, and others are opened in writing, as soon as practicable.
14. It is PPO policy that within 20 days of the notification, the designated Family Liaison Officer (FLO) makes telephone contact with the family. When there is difficulty identifying the family, the FLO contacts the police and coroner's officer to share information. The family is offered the opportunity to meet the investigator and FLO to discuss their concerns. They are provided with information about the PPO processes and the inquest, and details of other sources of advice. If the family is concerned about matters outside the TOR, the FLO will refer them to the appropriate agency which may include the Coroner.
15. All investigations include:
 - examination of the records
 - visit to the establishment where the death took place (or where the deceased lived previously)
 - meeting relevant staff and other prisoners/residents
 - a clinical review (except for deaths in approved premises)
 - providing feedback to the establishment on the findings of the investigation
 - a statement on the cause of death.

16. Prison Service Order 2520, "The Prisons and Probation Ombudsman" refers to the PPO's access to information, in particular:

"For the purpose of the investigations, the Ombudsman has unfettered access to Prison Service information, documents, establishments and individuals, including classified material and information provided to the Prison Service by other organisations, such as the police. All staff must co-operate fully with all requests from the Ombudsman or his/her staff for information, material or access to establishments and prisoners. Staff providing information to the Ombudsman or checking draft reports must identify to the Ombudsman any information which they consider should not be disclosed to the public.

"Examples will include circumstances where disclosure would be:

- i. Against the interests of national security
 - ii. Likely to prejudice the security of the prison
 - iii. Likely to put at risk a third party source of information
 - iv. Likely to be detrimental on medical or psychiatric grounds to the mental or physical health of a prisoner (or another person)
 - v. Likely to prejudice the administration of justice including legal proceedings
 - vi. Of papers capable of attracting legal privilege."
17. Each investigation of a death in custody includes a clinical review which is generally commissioned from the local Primary Care Trust. The PPO and Department of Health have provided guidance that the reviewer should be independent of the prison healthcare.
18. In addition, the majority of investigations include interviews with staff and prisoners/residents (unless there are no doubts about the veracity of the information already obtained). The investigator will select who to interview according to the circumstances of the case and will not be restricted to the date of the death. For example investigating an apparently self inflicted death might include interviewing education staff who knew the deceased, as well as wing and healthcare staff.
19. It is PPO policy that the list of interviewees will generally be drawn up after the investigator has read all the records and begun to identify the relevant issues. Interviews are generally conducted within a few weeks of the death. The interviews are usually recorded (unless the purpose is to gather general information, in which case a note would be taken). The PPO does not have powers under the Police and Criminal Evidence Act and interviews are not conducted under caution. The interviewee is provided with the transcript or note of the interview to check and sign. Statements are not generally taken and Coroners who require statements will need to make their own arrangements through the police or otherwise.
20. Investigators should maintain contact with the police and the Coroner throughout the investigation, according to the circumstances of the case and the police and coroner's working practices. Early liaison is of particular importance because the investigator may not have previous experience of the relevant coronial district. The PPO recognises the value in fostering close, professional working relationships and welcomes contact with the coroner. It is important that there is good liaison between the PPO investigator and the coroner's officer so that the Coroner knows whether there any individuals involved in the circumstances surrounding the death who are

not to be interviewed, or when interviews are likely to be delayed. This requires Coroners to accept that the PPO does not investigate on their behalf (see below).

21. In particular, the investigator will make the police and Coroner aware of any information which they need to know about urgently. This includes possible criminal offences and other matters that are outside the TOR. The investigator will alert the service in remit whenever findings emerge which require immediate action, such as a disciplinary investigation. The Coroner will be kept informed of such action which may cause delays to the investigation.
22. The post mortem report is essential to the PPO investigation and particularly to the clinical review and the Coroner will provide a copy of the post mortem report to the PPO without charge. The PPO will forward a copy to the clinical reviewer.
23. The PPO assumes that all the information obtained in the course of the investigation will be disclosed to the family, the service and the Coroner. When information is disclosed to one party, such as the family, either before or after the draft PPO report is published, the investigator will notify the other parties, and the Coroner. Information is disclosed unless there are specific exceptions. For example the PPO disclosure policy excludes documents such as those which might jeopardise the security of the establishment. Information will be provided in a redacted form to remove the names of other prisoners/residents but will retain the names of staff. Full unredacted disclosure will be given to the Coroner on request, without charge and the coroner will be supplied also with a copy of the redacted material.
24. The PPO documents sent to the family are accompanied by a letter advising that they should not be disclosed further, in case the inquest is prejudiced.
25. The PPO expects the Coroner to use the material solely for the purpose of the inquest touching the deceased, the subject of the investigation. Should the Coroner wish to make further disclosure of PPO material to persons interested in other cases, it should only be with the PPO's consent. Coroners will not disclose PPO material to those who are not properly interested in the particular inquest without the consent of the PPO, or without giving him a reasonable opportunity to make representations.
26. The current timescale for publishing the draft report is 20 weeks for a natural causes investigation and 26 weeks for all others. However, these timescales are dependent on a range of factors, many of which are beyond the PPO's control. The timeliness of the clinical review, and any representations made by the bereaved family or the relevant service, are critical to the process. For that reason, it is very rare for an investigation into an apparently self inflicted death to have gone through all its stages within six months.
27. Each draft report is issued in hard copy and electronic copy on request. When necessary the PPO will arrange for the report and clinical review to be translated for the family, but will not translate other evidence.
28. The report is accompanied by annexes which, at a minimum, include the transcripts of the interviews and the clinical review. Other documents will be annexed if they are open to interpretation. Evidence which has been seen by the investigator, but is not annexed, will be listed in the report – and provided to the Coroner and other parties on request.
29. When an individual is criticised in the report, it is disclosed in advance to the service in remit which has a period of time (generally 21 days) to comment. The majority of

reports do not require advance disclosure and are issued in draft to the family, service and coroner at the same time. Twenty-eight days is allowed for feedback to the report by the family and the service, after which the report is finalised and distributed again. The final pre inquest report will be marked as such. There are frequently further delays if one or other party asks for an extension to the 28 days. The changes, if any, will be notified to the Coroner.

30. From time to time the inquest takes place before the PPO report is disclosed. Regardless of this, the PPO report will continue to investigate. The report will be disclosed in draft and final form, and the anonymised published and copies sent to the Coroner.
31. Each investigation usually makes recommendations for improvements to performance, procedures and policy, both at a local and national level. The TOR do not include monitoring compliance with recommendations, unless they are pertinent to a subsequent investigation. However, the PPO has a Protocol with Her Majesty's Inspectorate of Prisons and supplies all recommendations, which can be monitored at their inspections. As well, the PPO's recommendations to prisons are shared with the National Offender Management Service.

The Role of the Coroner

32. The Coroner is an independent judicial officer with statutory responsibility for investigating the cause and circumstances of any death which may be violent, unnatural or of unknown cause or where the cause of death arose in prison. The Coroner has lawful physical control of the body in such circumstances and for all practical purposes is the only person who may authorise a post mortem examination.
33. The Coroner's service is a local service. Districts vary according to the size and nature of the area and population. Coroners are available at all times for certain functions, but many work part time. They are assisted by deputies and sometimes assistant coroners, as well as coroners' officers and administrative staff, often supplied by the local authority and/or local police force. Staffing levels are variable and often inadequate, as are the resources for administrative and judicial work. Liaison between the PPO and the Coroner will usually be between the investigator and the Coroner's officer.
34. Deaths occurring in prison will always be the subject of an inquest by a Coroner sitting with a jury. The Coroner will usually await the outcome of the PPO investigation before resuming the full inquest. The coronial jurisdiction is within the scope of the parliamentary sub judice rule, and the Contempt of Court Act 1981.
35. The role of the inquest into a death in custody is to determine the identity of the deceased, and to establish when, where and how the deceased came by his or her death. The inquest will ordinarily be the way in which the State fulfils its obligation under Article 2 of the European Convention on Human Rights to investigate, and this means establishing not only how the deceased came by his or her death, but also the circumstances in which the death occurred. The conclusions will be recorded as a verdict, which may take a narrative form.
36. The inquest is not a trial of rights and obligations, but a fact-finding exercise, with no parties or pleadings. The inquest verdict cannot determine or appear to determine civil liability. Verdicts appearing to determine criminal liability are permitted, but not on the part of a named person.

37. The Coroner must ensure that the relevant facts are fully and fairly investigated and are the subject of public scrutiny during the inquest hearing. Some individuals and agencies, for example, the family and the prison service, will be "interested persons" and thus entitled to participate in the coronial inquiry. (The PPO is not usually regarded as an interested person.) The Coroner alone is responsible for deciding on the scope of the inquest and the evidence to be called. The relevant issues will vary from case to case, and may or may not be the subject of disputed evidence. This means that the conduct of the inquest will also vary from case to case.
38. The process is inquisitorial, but the Coroners Rules 1984 create what some refer to as a hybrid system, which incorporates some adversarial procedures. Whilst the verdict cannot appear to determine liability, it can and should determine the facts, which may include failings on the part of individuals or agencies (albeit without naming individuals). Questioning at an inquest may be robust, but Coroners should disallow any question which in his or her opinion is not relevant or is otherwise not a proper question.
39. At the conclusion of the inquest the Coroner (but not the jury) may make a report to a person in authority under rule 43 of the Coroners Rules 1984 (as amended) if he or she believes that action should be taken to prevent the recurrence of similar fatalities. It would be unusual for the conduct of the investigation by the PPO to come within such a report.
40. A death in custody must be reported to the Coroner as soon as it is discovered (by his or her officer or other member of staff). The Coroner will make contact with the family and will formally open the inquest within a matter of days. From time to time the Coroner will be notified of the death of a recently released prisoner. The Ombudsman has the power to use his discretion to investigate such deaths and appreciates being notified of them.

Inquests

41. By making contact with the Coroner throughout the investigation, the PPO investigator and Coroner will be able to decide whether attendance at pre-inquest meetings would be useful. The PPO recognises that attendance is valuable, especially for extensive and complex investigations, as it helps to identify and resolve issues from all the parties. However, because of limited resources and travel factors, the PPO cannot attend every pre-inquest meeting for every case. Requests for attendance should not be made automatically but should be based on an assessment of the particular circumstances. The Coroner will ensure that the PPO investigator is informed of the hearing, and of any decisions and rulings made by the coroner.
42. The PPO is not resourced or qualified to provide administrative support to the inquest by managing exhibits or personnel. Whilst it is unusual for the PPO to retain original exhibits, the PPO investigator will ensure that any such items are provided to the coroner well in advance of the hearing.
43. It is for the Coroner to decide whether an investigator is required as a witness at an inquest. If the investigator is required, the investigator will liaise with the coroner's officer to agree reasonable attendance, the required date(s) and the likely evidence to be given. General information about the establishment or the service should be requested of the governor or equivalent. The investigator will usually be asked to confirm their role, and that an investigation has taken place. The conduct of the investigation is not normally a matter for the jury except insofar as it affects the

quality of other evidence before them. The investigator may also be asked to confirm factual findings, e.g. "during the course of your investigation, were you able to recover any CCTV footage of the landing".

44. The jury must judge the facts on the basis of the best direct evidence, and the conclusions of the PPO would not normally be regarded as "expert" evidence. Nevertheless there may be many occasions when the investigator is asked to give evidence about their recommendations and findings.
45. Examples of when the investigator may be asked to give evidence about their recommendations and findings include:
 - They may relate to issues that are not central to the inquest but which have caused concern.
 - Recommendations made in earlier cases may be relevant if it appears that action was not taken, leading to the continuance of circumstances that may have contributed to the current death.
 - To assist the Coroner in his or her responsibilities under Rule 43 of the Coroners Rules 1984 (as amended), in the absence of the jury where necessary.
 - To give general evidence about national legislation and guidelines concerning the Prison Service.
46. The nature of the case or the district may require a different approach, and Coroners will inform investigators if they are likely to depart from these general principles.
47. Should additional or conflicting information be disclosed once the PPO report is finalised or at inquest, the investigator will consider whether the report should be amended. For example an interviewee may change their evidence when it is given on oath. Also the Coroner may issue a rule 43 letter which may be relevant and incorporated into the report. When the amendments result in changes to the recommendations, the report will be re-issued in draft and feedback sought as before.
48. On receipt of the inquest verdict, the investigator will arrange for the anonymised report to be prepared and for the bereaved family to be offered the opportunity to comment before it is published on the PPO website and the case is closed.

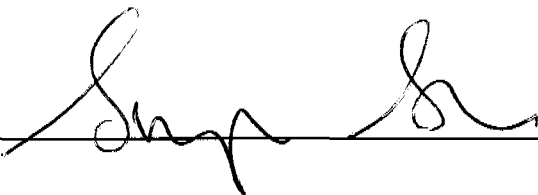
General

49. The Coroner will supply a copy of the Inquisition and any rule 43 reports to the PPO if requested. In subsequent investigations, the PPO will consider whether relevant recommendations have been complied with.
50. This is a continuing agreement which will take effect from 1 April 2009. The agreement will be subject to a formal review annually.

Signatories to the Agreement

The signatories to this agreement are the Prisons and Probation Ombudsman (on behalf of PPO) and the Coroners' Society of England and Wales (on behalf of CSEW)

Signature: **Prisons and Probation Ombudsman, Stephen Shaw**


_____ Date 1/7/2009

Signature: **The Coroners' Society of England and Wales, André Rebello**


_____ Date 25/06/2009