Ministry of Justice

HM Prison & Probation Service

Policy name: Reporting and Reviewing Deaths Under Probation Supervision in the Community

Reference: N/A

Issue Date: 06 June 2022 **Implementation Date**: 06 June 2022

Replaces the following documents (e.g. PSIs, PSOs, Custodial Service Specs) which are hereby cancelled: PI 01/2014 - Reviewing and Reporting Deaths of Offenders under Probation Supervision in the Community

Introduces amendments to the following documents: None

Action required by:

☐	HMPPS HQ	☐	Governors
☐	Public Sector Prisons	☐	Heads of Group
☐	Contracted Prisons	☐	Contract Managers in Probation Trusts
☒	Probation Service	☐	Under 18 Young Offender Institutions
☐	HMPPS Rehabilitation Contract Services Team	☐	HMPPS-run Immigration Removal Centres (IRCs)
☐	Other providers of Probation and Community Services		

Mandatory Actions: All groups referenced above must adhere to the Requirements section of this Policy Framework, which contains all mandatory actions.

How will this Policy Framework be audited or monitored: The policy framework requirements outline how each Probation region should assure the quality of death under supervision data and reviews.

Resource Impact: Notification and review procedures for Deaths Under Supervision (DUS) have applied since 2005 to supervised individuals subject to any form of statutory supervision. HMPPS have considered the changes in this revision and completed a resource impact assessment. Each individual change does not significantly increase the resource burden on the Probation Service. Although there has been a reported increase in the number of deaths since 2005, deaths of those under supervision still make less 1% of all those under supervision.

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CONTENTS

1. Purpose

1.1 This policy sets out the actions that must be taken following the death of a person under probation supervision. These outline the information to be gathered, recorded and shared and explains how this is used to inform understanding and learning about people who have died. It acknowledges the emotional impact that the death may have and ensures that the welfare needs of staff and others are considered.

1.2 Preventing deaths is not the primary responsibility of probation practitioners, but they can have an impact on the health of those under supervision, either through the work that they do to tackle health issues that are themselves criminogenic, risk factors, or barriers to effectively addressing offending behaviour, or by encouraging those under supervision to access services to address health-related needs. This policy describes how we use learning from deaths to improve our service and our approach to preventing deaths.

2. Evidence

2.1 A scheme for collating and publishing data for deaths of people under supervision in the community was first introduced in 2005, and data on deaths has been published annually since 2010-11. In the last two years central quality assurance of this data has revealed several issues with the way in which information is collected, recorded and reported, and this framework includes measures to improve those processes.

3. Outcomes

3.1 These are the outcomes which probation regions are expected to achieve from the policy.

- Information about the deaths of people under probation supervision are accurately recorded, updated and shared within the required timescales.
- Any risk, welfare or vulnerability concerns arising from a death are identified and appropriate actions are taken to mitigate them, including consideration of the welfare needs of staff and others affected by the death.
- Staff are provided with relevant information and supported when reviews into the death are completed by line managers, the PPO or Coroners.
- Line managers complete a review for all eligible deaths which draws out relevant learning points.
- Recommendations from independent investigations by PPO or Coroners and learning from line manager reviews are shared and actions implemented to improve our service and inform our approach to preventing deaths.

4. Requirements

4.1 Definitions and scope of this policy

4.1.1 This policy applies whenever a person has died in the community while under probation supervision because they were:

- subject to a court ordered community sentence, excluding suspended sentence orders with no requirements or a community sentence with a single electronic monitoring requirement.
- subject to post-custody supervision/licence following permanent release from prison, including individuals released on Home Detention Curfew, early compassionate release, or re-released after recall.

4.1.2 Deaths which occurred in the community while the individual was subject to breach or recall, in hospitals/psychiatric institutions, or resident in Approved Premises/other accommodation mandated by a court order or licence are in the scope of this policy, provided the person was under probation supervision at the time of the death as defined.

Deaths in custody, during temporary release or after probation supervision has ended

4.1.3 Whenever the Probation Service is notified about deaths in prison custody or which occurred before the individuals' permanent release from prison or while the person was not subject to probation supervision, a record should be made in Delius in accordance with Case Recording Instructions CRI026; the Victim Liaison Service should be notified if any victim is eligible for the victim contact scheme, the welfare needs of staff, family members and others should be considered and the community probation practitioner must consider if the circumstances of the death raise any risk or welfare concerns (as required under paragraphs 4.3 and 4.4 below). Once these actions are completed Delius can be terminated; there is no requirement under this policy framework to complete a notification, review, or to seek/record further information about the circumstances of these deaths.

Roles and responsibilities

4.1.4 Each probation region should appoint a lead for Deaths Under Supervision at senior management level and an administrative lead for Deaths Under Supervision, whose responsibilities are outlined in relevant sections below. Reference to the allocated practitioner and line manager refers to the probation practitioner who was allocated to supervise the individual at the time of their death. However, in relevant circumstances (such as unplanned leave, or due to welfare considerations), tasks can be allocated to other practitioners at the discretion of a line manager, Head of PDU or senior lead for Deaths Under Supervision.

4.2 Notification to the Probation Service about the death of a person under supervision

4.2.1 The staff member who receives the initial notification of the death must inform their line manager. A line manager must inform the allocated practitioner about the death when the initial notification was received by another member of staff.

4.2.2 To ensure familiarity with required actions, which may have changed if staff were previously involved in the death of a supervised individual, it is recommended to read section 4.4 of this policy, Case Recording Instructions CRI026 and EQuiP process map "Deaths Under Probation Supervision" in their entirety.

4.3 Staff welfare and support

4.3.1 By its nature, this policy framework applies in difficult circumstances and the welfare needs of staff must be considered throughout its application.

4.3.2 Line managers should provide immediate support, meet the staff member within 2 working days of being notified of a death and discuss individualised support options. Welfare needs

should be considered beyond the immediate notification of a death; it is recommended to review these within one month and at other key stages, particularly the completion of a death under supervision review or when staff are required to contribute to coroner's inquests or investigations by the Prison and Probation Ombudsman. "Supporting staff after a death under supervision – Guidance for Line Managers", should be consulted.

4.4 Responsibilities of the allocated practitioner for all deaths under supervision

4.4.1 Upon being notified about a death, a record should be made in Delius indicating the person has died in accordance with Case Recording Instructions CRI026. The "Death Under Supervision Initial Notification and Review" form should be generated in Delius and an email sent to the Probation region's death under supervision mailbox to advise that a death has been notified (email addresses are listed on that form).

4.4.2 Whenever the notification has been made by a family member or acquaintance of the deceased, the death must be confirmed through an official source (See section 5.3 Annex A: Seeking information about the circumstances of a death).

4.4.3 Within 2 working days of being notified of a death, the practitioner should:

- Consider, in conjunction with their line manager (and Approved Premises manager where applicable), if the circumstances of the death raise any immediate concerns or risks and take actions to mitigate these. This includes (but is not limited to), risk, welfare or vulnerability concerns relating to any known children, adults, vulnerable adults or individuals supervised by the Probation Service; or un-identified individuals (such as clusters of drug-related deaths or suicide, or risk of violence to others).
- Amend or delete case records relating to future appointments and mobile telephone numbers, so that letters/texts relating to attendance are not mistakenly sent.
- Notify the Victim Liaison Service whenever any victim of the deceased is eligible for the victim contact scheme, whether the victim is participating or not.
- Notify the PPCS if the individual is subject to a life/indeterminate licence.

4.4.4 Within 10 working days of being notified of a death the practitioner should seek further information to determine an apparent category and date of death (see section 5.3, Annex A: Seeking information about the circumstances of a death), ensure these are entered into Delius in accordance with Case Recording Instructions CRI026, complete the Initial Notification and Review form in Delius and send this to their line manager, the Probation region's death under supervision mailbox listed on that form and to their PDU administrator. Practitioners can request a PDU administrator to enter the category and date of death.

4.4.5 The assigned category may reflect a confirmed cause of death (when this has been provided by a coroner, registrar, medical practitioner/medical information, or a death certificate), or may be a provisional categorisation (for instance, where a coroner's inquest is taking place or where information about a confirmed cause of death has not been received). There may not be certainty at this stage and staff are encouraged to use the information that they have, to make a judgement on the balance of probabilities wherever possible, and to use the "Other: Awaiting Further Information" category only where there is little or no information available about the apparent cause.

4.4.6 The following definitions should be used to determine the apparent category of death:

Homicide: Shooting; Stabbing; Other
Any death of a person at the hands of another.

Natural causes: Cancer Related; Heart related; Other

Any death of a person as a result of a naturally occurring disease process. This includes those contributed to by alcohol or drug dependence (where the death was related to the effects of long-term substance use) but not poisoning in a specific incident.

Self-inflicted: Drug poisoning (intentional or undetermined); Fall from height (intentional or undetermined); Hanging; Other
Any death of a person at their own hand, including where intent is undetermined. This includes some drug poisonings (e.g. where a suicide note is found or the circumstances are suspicious) but not drug poisonings which appear to have been the accidental result of consumption for another purpose.

Other: non-natural – Drug poisoning (unintentional); Alcohol poisoning; Fall from height (unintentional); Road Traffic Accident; Other non-natural: Other; Other non-natural: Unknown
Any death of a person that cannot easily be classified as natural causes, self-inflicted or homicide. This includes accidents arising from external causes, including apparently accidental alcohol and drug poisoning and deaths of which, even after all investigations have been concluded, the cause remains unascertained or unknown.

Other: awaiting further information *- It is not possible to assign one of the above categories from the information currently available.*

Amending the category/date of death upon receipt of additional information

4.4.7 Any further information which is received about the circumstances of the death should be entered into Delius in accordance with Case Recording Instructions CRI026. The practitioner should review the previously assigned category of death to establish whether it is accurate and where it is not, arrange for the updated category of death to be reflected in Delius as outlined in Case Recording Instructions CRI026.

4.4.8 It is important to send this information to the Probation region's death under supervision mailbox and indicate if the information is a confirmed cause of death provided by a coroner, registrar, medical practitioner/information or death certificate, so that staff administering deaths under supervision do not continue to seek the official cause of death.

Considering the welfare needs of others

4.4.9 The allocated practitioner, in conjunction with their line manager, should identify other staff members who have been involved in the person's supervision, agree who should notify them and the most appropriate method to do so, so that their support needs can also be considered by their line manager.

4.4.10 The Probation Service should not notify family members or friends about a death. However, the allocated practitioner and their line manager should consider whether it is appropriate to contact the next-of-kin, family members and/or the intimate partner of the deceased to offer condolences and signpost to support options, in accordance with "Guidance for practitioners – Support for staff, family and others after a death under supervision" in EQuiP. They should consider who is best positioned to make this contact and what form this contact should take or make a record in the deceased person's case records if there are reasons to consider that such contact should not be made.

4.4.11 Where an individual supervised by the Probation Service has been affected by bereavement, their welfare needs should be discussed and explored with them by their allocated practitioner, including signposting to support options, in accordance with

"Guidance for practitioners - Support for staff, family and others after a death under supervision" in EQuiP.

OASys Terminations

4.4.12 OASys Termination guidance should be consulted and followed, to establish the requirements for ensuring OASys is appropriately terminated.

4.5 Responsibilities of the line manager for all deaths under supervision

4.5.1 In conjunction with the allocated practitioner, the line manager should ensure the welfare needs of the practitioner and others have been fully considered, as required by sections 4.3 and 4.4.9 above.

4.5.2 Within 2 working days of a death being notified, the line manager should discuss with the practitioner to consider if the circumstances of the death raise any immediate concerns or risks and that actions are taken to mitigate these, as specified in section 4.4 above.

4.5.3 Upon receipt, the line manager should review the completed Death Under Supervision Initial Notification and Review form, confirm that any risks or immediate concerns have been addressed and that the category/date of death have been correctly assigned and entered into Delius and amend/enter these where necessary. They should also determine whether a "Full Death Under Supervision Review by Line Manager" is required, as outlined in paragraph 4.8. If a full review is not required, the Death Under Supervision Initial Notification and Review form should be sent to the Probation region's death under supervision mailbox and to the Head of Probation Delivery Unit.

4.5.4 The line manager must consider whether the circumstances of the death or immediate risks relating to it, indicate that escalation is required to a senior manager, via the Head of Probation Delivery Unit, or whether the media policy needs to be consulted or followed. Significant concerns which may result in potential harm to other individuals if immediate actions are not taken should be escalated.

4.6 Terminating Delius Records

4.6 Delius records should be terminated, in accordance with termination guidance outlined in Case Recording Instructions CRI026, once the apparent category and date of death have been entered into Delius and any other recording requirements outlined in CRI026 have been completed, which should be completed within 10 working days. If any of these fields are not present, the person terminating the case should seek this information from the allocated practitioner and ensure these are entered before the case is closed. Data relating to the person on probation, such as personal circumstances and risk registers should reflect their circumstances before they died and the person terminating the case records must ensure information about Equality Monitoring has been entered and is complete.

4.7 Deaths of Approved Premises residents or on Probation Premises

4.7.1 All requirements above apply to deaths which occur within Approved Premises (AP) or relate to AP residents. Therefore, it is the responsibility of the allocated practitioner to ensure that tasks outlined in section 4.4 have been completed. However, the allocated practitioner should liaise closely with the AP manager so that tasks are not duplicated and to seek relevant information; for instance, further information about the circumstances of the death may already be known to AP staff and AP staff may also appoint a family liaison officer to liaise with family members.

4.7.2 AP staff must adhere to relevant AP instructions relating to the death of a resident. AP staff should invite the allocated probation practitioner to any de-brief meetings or group welfare support meetings which are arranged.

4.7.3 All requirements within this policy also apply where the death occurred on probation premises. Staff should also contribute to any Health and Safety investigations that occur in parallel.

4.8 Completion of a full death under supervision review by line manager

4.8.1 A full death under supervision review should be completed by the allocated practitioner's line manager (or another line manager) in all cases except:

- Where the PPO have confirmed that they will be completing an investigation or where the death relates to a resident of Approved Premises
- Where the death was expected (for example a death resulting solely from a diagnosed terminal or long-term physical condition)
- Where the death resulted from an accident which did not involve drugs, alcohol and where there is no evidence of the presence of a known risk factor e.g., as listed in Section 1.4 of the 'Initial notification and review' form

4.8.2 Where these exclusions apply, the form should still be submitted to the Probation region's death under supervision mailbox and Head of Probation Delivery Unit, outlining the reason for exclusion and indicating whether any amendments to the assigned category of death are required and have been made in Delius.

4.8.3 The review should be completed once there is enough information regarding the circumstances of the death or within 1 month, whichever is sooner. Where the cause of death remains uncertain and no further information or inquest will be forthcoming, the review should still be completed based on the best available information.

4.8.4 Before the review, the reviewer should fully discuss its purpose with relevant staff members. Discussions should be held with staff involved with the case but there is no requirement for formal staff interviews.

4.8.5 The review should not seek to explain the death, its contributors nor attribute responsibility for the person's death; further guidance on completing the review by the line manager in section 5.3 Annex B, should be consulted.

The functions of the review are to:

- gather information regarding the circumstances of the death (including confirming categorisation)
- provide an overview of the person's supervision throughout their sentence (which could be used if needed to assist with information requests from Coroners)
- identify relevant factors in the person's history and any good practice, practice improvements, difficulties or barriers in addressing identified needs
- consider where lessons can be learnt so services can be developed, where necessary, at either a local or national level
- enable discussion with staff who might be affected by the death, in line with employee care policies

4.8.6 At a minimum, the line manager should access written case records and assessments (e.g. Delius and OASys) over the previous 12 months or current sentence. Where a death has

occurred within 6 months of release from prison, probation case records relevant to the custodial period should also be consulted.

4.8.7 Where the line manager identifies good practice or the opportunity for practice improvement or considers that there are lessons which can be learnt at a local or national level, recommendations should made in the review report.

4.8.8 Whilst the review is focussed on understanding the case and developing learning, it is possible that gaps in an individual's knowledge or skills may be identified during the review. In this event, the line manager should undertake proportional action, in line with current policies.

4.8.9 All completed reviews should be sent to the Probation region's death under supervision mailbox and to the Head of PDU. Reviews are utilised by the Head of PDU, regional Death Under Supervision Leads, HMPPS and other practitioners (such as regional suicide prevention or health leads) to identify themes and learning to improve service delivery as outlined in section 4.14 below.

4.9 Responsibilities of Death Under Supervision Administrators for all deaths

4.9.1 Each probation region should appoint a death under supervision administrator/s who should log the details of any deaths notified onto the regional register of deaths, complete any tasks outlined on the register and update it when further information is received.

4.9.2 Upon being notified about a death for the first time, the administrator should send a response, including a support about bereavement, to the allocated probation practitioner and to their line manager.

4.9.3 Whenever an "Initial Notification and Review" form is received, the administrator should verify whether the apparent category and date of death have been entered into Delius and that any other recording requirements outlined in Case Recording Instructions CRI026 have been completed and where they have not, either contact the practitioner's administrator to ensure these are completed, or (where instructed by the regional lead for deaths under supervision) to enter the missing information directly.

4.9.4 Whenever an "Initial Notification and Review" form relates to an individual who died within 28 days of release from custody, this should be forwarded to the National Incident Management Unit and to HMPPS Death Under Supervision mailbox.

4.9.5 Copies of "Initial Notification and Review forms" and "Full reviews" should be saved in line with local record retention policies. Information from these should be recorded by the regional DUS administrator as outlined in the EQuiP Death Under Supervision process. These forms, and the regional register of deaths, do not need to be routinely submitted to HMPPS but must be sent when requested.

<u>Seeking official causes of death and reviewing the apparent category</u>

4.9.6 Whenever a death has been notified and the assigned category of death has not determined by the practitioner upon the basis of a confirmed cause of death provided by a coroner, registrar, medical practitioner/information or death certificate, it is the responsibility of the DUS administrator to seek an official cause of death (in accordance with section 5.3 Annex A: Seeking information about the circumstances of a death).

4.9.7 For these deaths, the DUS administrator should contact the relevant coroner's office 6-9 months after the death to request whether an inquest has taken place and the coroner's

conclusion. If the coroner's office confirms that an inquest will be taking place but has not yet occurred, further contact should be made at 3-monthly intervals to seek this information (or after the date of the inquest, where this is known).

4.9.8 If the coroner's office advises that no inquest is taking place and they do not have information about the death, the Death Under Supervision administrator should contact the relevant registrar, to ask them to provide the cause of death. If the registrar advises that this information cannot be provided without payment of a death certificate, the Death Under Supervision administrator should arrange to pay for the death certificate, in line with local policies.

4.9.9 Once an official cause of death has been provided by a coroner, registrar or death certificate, the DUS administrator should log this information onto the regional register of deaths under supervision. The senior lead for deaths under supervision should review these deaths before the end of the annual reporting year, to establish whether the assigned category of death needs to be amended and if so, arrange for the updated category of death to be reflected in Delius, as outlined in Case Recording Instructions CRI026.

4.10 Investigations by the Prison and Probation Ombudsman (PPO)

4.10.1 The Prison and Probation Ombudsman (PPO) is an independent body appointed by the Secretary of State for Justice to carry out investigations into deaths, due to any cause, of prisoners, young people in detention, residents of Approved Premises and detainees in immigration centres and has discretion to investigate the deaths of individuals who were recently released from state custody. The purpose of these investigations is to understand what happened and to identify learning for the organisations they oversee.

4.10.2 Staff must co-operate with requests from PPO staff, including participating in interviews about their work or providing information to the PPO about the person's supervision.

4.10.3 Whenever a probation region is notified that the PPO are investigating a death, a practitioner of at least SPO grade must be appointed as PPO liaison (this is not the allocated probation practitioner's line manager). It is the role of the PPO liaison to notify practitioners involved in the supervision of the person and their line managers about the investigation, to ensure they are fully briefed about its role and purpose and to collate/provide documentation as requested by the PPO in accordance with guidance available in EQuiP "PPO investigations into Deaths Under Probation Supervision: Guidance for Probation Regions". Where documentation is required from Approved Premises, the PPO Liaison should request the AP manager to arrange for this to be sent to the PPO.

4.10.4 The relevant Approved Premises will be notified whenever the PPO are investigating the death of an AP resident. Whenever PPO staff indicate the investigation will involve seeking information from or interviewing non-AP staff, the AP manager should contact the Safer Custody Casework Team to request that a PPO Liaison is allocated so that tasks as outlined in paragraph 4.10.3 are completed. Further information is available in "PPO investigations into Deaths Under Probation Supervision: Guidance for Probation Regions".

<u>Responding to the PPO report</u>

4.10.5 The PPO aim to submit a report and any recommendations to HMPPS Safer Custody Casework team (for deaths of non-AP residents) or to the National AP team (for AP residents) within 20 weeks (for natural cause deaths) or 26 weeks (for all other deaths). This report is submitted to other parties, including the person's next-of-kin and, where relevant, coroners.

4.10.6 The Safer Custody Casework Team/National AP team will send the report to the PPO Liaison, DUS lead and prison (where relevant). It is the responsibility of the probation region to undertake a factual accuracy check and to respond to any relevant recommendations by producing an action plan, with the final response co-ordinated by the Safer Custody Casework Team or National AP team, as relevant.

4.10.7 A final report will then be issued by the PPO to the central casework team which includes the completed action plan. This will be provided to the relevant PPO liaison and DUS Lead and HMPPS directorate, for national recommendations. Monitoring of the completion of probation actions lie with the relevant central or regional Directors.

4.10.8 In cases in which an inquest is to be held, this is sent to the Coroner. A version is published on the PPO's website after the inquest has concluded.

4.11 Coroner's Inquests

4.11.1 Probation Service staff must co-operate with any requests from a Coroner to participate in or provide information to inform an inquest. Whenever any Probation Service staff member is approached for information about a death by a Coroner, asked to provide a statement, or asked to attend a hearing as a witness, the Government Legal Department must be contacted as soon as possible. Staff must consult and follow Probation Service Guidance on Inquests (this is linked in EQuiP Death Under Supervision process, or Inquests).

4.11.2 Staff should also inform their line manager and the Probation region's lead for litigation/inquests (Head of Corporate Services), so that further advice, guidance, and support can be offered. Further guidance can also be consulted to support staff, "Supporting staff after a death under supervision – Guidance for Line Managers" in EQuiP.

4.12 Police investigations

4.12.1 Any police investigation will have primacy over other investigations. The police have a memorandum of understanding with the PPO as to how an investigation will proceed when there is a possible or actual crime, including suspending PPO investigations where relevant.

4.12.2 The Regional Probation Director must be notified if the police decide to interview any member of staff under caution and if staff are charged by the police with an offence.

4.13 Role and function of the regional Deaths Under Supervision Lead

4.13.1 Each probation region shall appoint a lead for deaths under supervision at senior management level, who must ensure:

- That staff within the probation region are aware of their responsibilities under this policy framework whenever a death has occurred
- To ensure that death under supervision administrators are aware of their responsibilities and to provide oversight and assistance of their work
- To review the regional register of deaths under supervision at least on a quarterly basis to ensure that all deaths are designated the correct category of death in line with the paragraph 4.4 and to ensure these are amended to the correct designation, where required, both in case records and on the regional register.
- To work with the Performance and Quality Team on a quarterly basis to produce a list of deaths under supervision within a designated time period and to ensure each

of these have relevant data recorded in Delius, a death under supervision notification and death under supervision review (where required).

- To assure the quality of all DUS review reports, where necessary returning them to line managers for additional work to be completed.
- To ensure that action is taken to address issues identified in DUS review reports, PPO recommendations and Coroner's Prevention of Future Death reports.
- To ensure that DUS data and learning from DUS full review reports is shared with regional leads responsible for specific areas of work, including suicide prevention, health and public protection and to commission learning reviews
- To ensure that management information on deaths under supervision is reviewed and used to inform action to prevent deaths.

4.14 Analysis of DUS data and reviews

4.14.1 The full reviews should be used to inform individual, local and national learning and service developments. The full review should be used by the line manager to provide any relevant feedback for those involved in the case and by the Head of PDU to initiate local action on the basis of the findings.

4.14.2 Each region should ensure that a senior manager considers all relevant DUS information (including DUS data, initial notification and reviews and full reviews, PPO recommendations and any coroner's prevention of death reports) on an annual basis to identify and learn from the circumstances of people who die under probation supervision, including identifying changes to practice which may support the prevention of future deaths. HMPPS will provide an annual learning summary which identifies any required changes to national practice.

5. Guidance

EQuiP process map

5.1 For additional guidance and an overview of the steps which are required under this policy framework, staff can consult EQuiP, Deaths Under Supervision process map.

Associated Guidance

5.2 EQuiP contains the following guidance relevant to the implementation of this policy:

- Supporting staff after a death under supervision – Guidance for Line Managers
- Guidance for practitioners - Support for staff, family and others after a death under supervision
- PPO investigations into Deaths Under Probation Supervision: Guidance for Probation Regions
- Probation Service Guidance on Inquests
- Case Recording Instructions CRI026
- Approved Premises: EQuiP process "Death of a resident" and Safe Working Practice document.
- EQuiP process: Victims
- EQuiP process: Death in Custody

Annex A

Seeking Information about the circumstances of a death

Confirming the death and determining an apparent category of death

Where family members or an acquaintance of the deceased has notified the probation service about a death, the death must be confirmed through an official source. The supervising officer must also seek information to determine an apparent category and date of death (and enter these into Delius in accordance with Case Recording Instructions CRI026). While family members should not be contacted solely for information about a death, where they have volunteered to provide information or a death certificate, these can be used to inform the determination.

Entering the category and date of death into Delius is crucial for HMPPS to collate an annual statistical publication of deaths under supervision, so it is important that this data is complete, accurate and updated where required. This information is used to further understanding about the people who have died under supervision.

Official sources to confirm a death or to determine the apparent category will differ depending on which agencies are involved and the type of death. Officers should therefore use their discretion to identify which agencies are likely to hold information and when to contact them. For example, coroners and registrars may not have been notified about a death immediately after it occurred, so it is advised not to contact these agencies until at least a week after the date of death.

Official sources to confirm the death and apparent category include:

- Local police
- Medical practitioners or medical information (such as hospitals who treated the person when they died, nursing home staff, GP's or medical information provided by the supervised individual about a known diagnosis)
- Accommodation provider or AP manager (if the person died while resident)
- Other involved agencies/practitioners such as social workers, mental health practitioners, drug/alcohol practitioners
- Coroners and registrars (see below)
- Death certificate (an interim death certificate confirms that the person has died but does not include information about the circumstances or cause of death)

Coroners conduct an inquest when there is reasonable suspicion that the deceased has died a violent or unnatural death and where the cause of death is unknown. Where an inquest is being conducted, the official cause of death will not be known until after the conclusion of the inquest, usually 6-9 months later. In these cases, the apparent category of death will need to be determined upon the basis of other apparent information, as outlined in section 4.4.4.

In other cases, a doctor will issue a certificate to register the cause of death with the registrar; coroners may also hold and be able to provide the cause of death for some of these. The Probation Service does not need an actual copy of the death certificate; where a coroner holds no information, ask the registrar to provide a cause of death without a copy of the death certificate.

Coroner's offices contact details can be found here: https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/the-appointment-of-senior-coroners/
Register offices contact details can be found here: https://www.gov.uk/register-offices

Staff should advise coroners, registrars and other agencies that this information is needed because the Probation Service is required to report all deaths of individuals on probation supervision to the Ministry of Justice, including the apparent cause and dates of death.

Seeking official causes of death and reviewing the apparent category

Where an apparent category of death was not determined by the allocated practitioner upon the basis of an official cause of death provided by a coroner, registrar, medical practitioner/information, or death certificate, administrative staff should seek these outcomes as described in section 4.9.6. The allocated practitioner should support administrative staff to seek this information when they are requested to do so, and when they are requested to update the apparent category of death where this is required, as outlined in section 4.4.7.

Annex B

Reviews by Line Managers: Guidance

The line manager should, for all cases (even if exempted from a full review) ensure they complete Section Two of the review form, to confirm the apparent cause of death, that case recording has been completed and any exemption reasons and send to their Head of Probation Delivery Unit and regional mailbox for deaths under supervision.

Where a full review is required, the line manager should work with the allocated practitioner to complete the review, once sufficient information regarding the apparent cause of death has been obtained or within one month of the death.

Where the cause of death remains uncertain and no further information or inquest will be forthcoming, the review should still be completed based on the best available information.

What should a full review cover?

An approach of how, what and why should be adopted. Not who was to blame. The following key questions should be covered:

- How and when did the person die?
- What were the significant circumstances in the persons' life?
- What were the identified risks and needs of the person? How were they recorded, shared and managed?
  This includes looking at the practitioners' own supervision of the person, such as the delivery of sentence plans, supervision appointments and interventions, or work delivered by other agencies and how this was co-ordinated.
- Was the person's case management appropriate to expectations in current guidance (e.g., were local and national policies, procedures and guidance followed)?
  This may, for instance, require you to consult guidance or policies relating to suicide prevention, drug/alcohol treatment, delivery of interventions, identifying and managing risks to self, risk management and sentence plans.
- What difficulties or barriers were there in addressing identified risks and needs?
- Are there any learning opportunities at an individual, local or national level?
- Is there learning, process changes or additional guidance which might support the prevention of future deaths in similar circumstances?
- Are there any examples of good practice?
- Whether, in hindsight, there were indicators of factors being present, which could be used to identify the presence of the factor/s in the future.

What information should inform a review?

The review should at a minimum: access written case records and assessments (e.g. Delius and OASys) over the previous 12 months or current sentence (including in prison, where relevant); include discussions with involved staff members; identify gaps or missing information and review information sharing and interactions with other agencies. The review should also cover relevant

aspects to the death e.g. known risk-to-self, drug history or physical health and adapt the review dependent on circumstances.

Although the review is not considering whether factors contributed to the death, probation practitioners may have identified health and wellbeing concerns or other factors e.g. lack of accommodation or suicide concerns and can provide support for those areas through management plans and sentence plans, initiate referrals or encourage supervised individuals to access available services to address these. The focus of reviews is to understand what was known and whether opportunities were taken to address health-related concerns, any difficulties or barriers encountered, to identify good practices or practices which could be improved.

External agencies

It is not required to gain information from other agencies as this is an internal review and is not seeking to understand the full circumstances of the case or the death. However, where the review identifies queries or issues in the interaction between agencies, then these should be noted on the form and the Head of PDU consider the appropriate action. We should not provide recommendations or criticism of another agency but information or the review can be provided to support the relevant agency's own review or learning.

The review may be disclosable in investigations into the death by a Coroner, who may share with others, including family members, so it will be important for the reviewer to consider carefully their use of language and to ensure that the content is appropriate for all potential audiences.

Prison Leavers

Where a death has occurred within 6 months of release from prison, probation case records relevant to the custodial period should also be consulted and the prison offender management unit contacted to understand how identified factors were addressed while the person was in custody and preparations for release.

Any learning points which may have relevance to prison staff should be shared with the Head of the Offender Management Unit in prison by the Probation Service Death Under Supervision senior manager.