Service Model Policy and Guidance: Casework reference library

Version 4.0

Quality Directorate

Version: 4.0
Version date: 13/11/2017

Contents

Version: 4.0
Version date: 13/11/2017

Introduction

1. The Parliamentary and Health Service Ombudsman's casework process is summarised in the Service Model. This guidance provides information about how our casework staff should operate in line with the Service Model.

2. The Service Charter contains 18 commitments about how we will deliver our service and what people can expect when they bring a complaint to us. The detailed information in the Service Model and this guidance helps us to deliver our service in line with the Charter commitments.

3. The intention of the guidance is to provide an additional layer of detail below the Service Model, with a particular focus on:

   - Requirements from the law (flagged as 'Legal requirement' in the text).
   - Requirements from our own policy (flagged as 'Policy requirement' in the text).

4. Those requirements set the framework within which our casework staff should operate. The guidance is not intended to prescribe the actions or process to be followed across all casework and in all circumstances. Many areas of casework require discretion and judgement and depend on the specific circumstances of the case. Any divergence from the stated requirements in the guidance should be recorded and explained on our case management system; Microsoft Dynamics (MSD).

5. The Supervision Model specifies the tasks and supervisory tasks that are required to complete PHSO casework. The Supervision Model and supporting guidance detail the minimal supervision requirements of staff processing casework. Staff must adhere to the Supervision Model at all times.

6. Please note that when the text of the guidance refers generally to 'caseworkers', this covers both 'caseworkers' and 'senior caseworkers'. The distinction between what the two types of caseworkers can do is set out in the Supervision Model and the Delegation Scheme.

7. This guidance document is a supplement to the main casework guidance and focuses on specific subject areas within our casework where separate guidance is required. Our general guidance provides further detail about how specific areas of our casework process should be completed.

8. We also have a selection of briefing notes covering specialised or specific areas of our casework processes. A link to all current available briefings is included in annex A of this document.

9. The guidance references key information about MSD processes and these are highlighted between blue lines in the text.

10. The guidance is a living document and will be updated on a regular basis.

11. The guidance is owned and maintained, on behalf of Operations, by the Quality and Service Integrity Directorate.

12. If you have any feedback or questions about the guidance or related issues then please email: ++ServiceModelGuidance@ombudsman.org.uk

1. What to do if an MP leaves office or dies and what to do if the complainant moves constituency

Member of Parliament leaves office or dies during our consideration of a case

1.1 If a referring MP (Parliamentary) or MP who assisted in the making of the complaint (Health) dies or leaves office while we are handling a case, then we treat their successor as the 'appropriate' MP for the purposes of the 1967 and 1993 Acts[1]. **(Legal requirement)** We should therefore send them a copy of our decision not to investigate or copies of our draft and final report as appropriate. **(Policy requirement)**

1.2 While waiting for a new MP to be elected we can still send decisions not to investigate or reports to other involved parties, for example; the complainant or organisation complained about. We should clarify to the complainant that we will send a copy of the decision or report once they have a new MP. The decision not to investigate or report must then be issued to the new MP once elected. **(Policy requirements)**

1.3 When contacting a new MP for the first time we should explain that we are writing to them because their predecessor either referred or assisted in the making of the complaint. **(Policy requirement)**

1.4 If a new MP is elected during an investigation then it may be appropriate to contact them to say that we will be corresponding with them as the investigation progresses, as opposed to only making contact at the time when we are issuing the draft or final report. Such decisions should be taken on a case-by-case basis.

1.5 The caseworker should ensure a copy of the decision letter or report is sent to the MP who is elected. **(Legal requirement)** We do not need to send acknowledgement letters or proposal to accept for investigation letters out in these circumstances. **(Policy requirement)**

1.6 Once a new MP is elected their details should be added as a separate MP record on MSD. The caseworker adding the new MP should make a request to the MSD Pilot Team that the previous record is made inactive. **(Policy requirement)**

[1] 1967 Act, section 10(1); 1993 Act, section 14

Complainant moves constituency in a complaint referred by a Member of Parliament

1.7 On occasion a complainant may change their address, and in the process their parliamentary constituency, while we are still considering their case. In these circumstances we are still required to send our final decision or investigation report to the original MP who referred the case.

1.8 This is because, in Parliamentary cases, section 10(1) of the 1967 Act requires that we send a decision not to investigate or an investigation report to the referring MP **(Legal requirement)**. Similarly in Health cases, where a complainant has chosen to put their complaint through an MP, section 14 (1 & 2) requires us to send our decision not to investigate or investigation report to any MP who assisted in the making of the complaint[2] **(Legal requirement).**

1.9 There is nothing to prevent us from still sending decisions or reports to the 'new MP', if the complainant asks us to do so. We should explain in our initial contact with the 'new' MP the reasons we are sending them the decision or report and that this is at the request of the complainant. **(Policy requirement)**

[2] Further information about the process of issuing decision letters is available from paragraph 3.63 in the Service Model main guidance.

2. Detention under the Mental Health Act (MHA)

Who can consider complaints about care and treatment under the Mental Health Act 1983?

2.1 We are one of four organisations that can deal with complaints involving people detained or treated under the Mental Health Act 1983 (MHA). Each has different powers and responsibilities. The other organisations are:

- The First-tier Tribunal (Mental Health) (the Tribunal).
- The Local Government Ombudsman (LGO).
- The Care Quality Commission (CQC).

2.2 The decision whether a case is for us or another organisation to consider should usually be resolved as part of the assessment process. **(Policy requirement)**

2.3 When considering a case that involves the MHA, the caseworker should consider which organisation is more appropriately placed to look at the case and achieve the remedy sought. **(Policy requirement)** We can also decide that different parts of the complaint should be considered by different organisations.

2.4 If a caseworker considering a case is unsure about whether we can consider a complaint made to us or whether a case is more suitable for the CQC, then they should request jurisdictional or legal advice. **(Policy requirement)**

2.5 A legal briefing note that covers our jurisdiction for complaints made by someone detained under the MHA is available[3].

Who can make decisions under the MHA?

2.6 There are four main groups of people who have decision making powers under the MHA:

- Approved mental health professionals.
- Approved clinicians.
- Responsible clinicians.
- Hospital Managers.

[3] Link to the Mental Health Act briefing note

2.7 Approved mental health professionals, usually social workers, have the power to assess a person and apply for them to be detained. They perform their role on behalf of the local authority.

2.8 Approved clinicians are medical professionals who have powers given to them directly by the Department of Health in England and Welsh Ministers in Wales, to make decisions under the MHA. They are involved in the approval process of deciding if someone should be detained under the MHA. They undertake actions as an individual and not on behalf of the NHS.

2.9 Responsible clinicians are approved clinicians who also take responsibility for a person's care and treatment while they are detained. They undertake actions as an individual and not on behalf of the NHS.

2.10 Hospital managers are people who work within hospitals to make sure the MHA is applied correctly. They also have some decision making responsibilities. They take actions on behalf of the NHS Trust they are employed by.

Complaints generally for us

2.11 Complaints more suitable for us usually relate to general care and treatment that could have been received by someone who was not detained under the MHA. For example, a complaint about receiving poor care for a foot injury or not receiving medication for a condition unrelated to the person's mental health.

2.12 We are generally best placed to consider complaints about how staff have carried out actions allowed under the MHA. For example, we could consider a complaint about a staff member being too forceful when restraining someone.

2.13 We can also consider complaints about the actions hospital managers are permitted to take under the MHA. For example, the decision to transfer someone from one hospital to another, or to seclude someone. If the complaint also relates to the actions of an individual we cannot consider though, (for example, an approved or responsible clinician), we must consider if the CQC is better placed to handle the complaint. **(Policy requirement)**

Complaints generally for the First-tier Tribunal (Mental Health)

2.14 The Tribunal deals with complaints about the decision to detain someone under the MHA, the conditions placed on a conditional discharge from hospital or the decision made to apply a community treatment order.

2.15 As the Tribunal (Mental Health) is a statutory route of appeal, it is an alternative legal remedy. We therefore must consider if it is reasonable to expect the complainant to pursue it. **(Legal requirement)**

2.16 A complaint will usually be for the Tribunal and not us if the outcome the complainant is seeking is one the Tribunal can achieve but we cannot (such as the overturning of a decision to detain someone).

2.17 Sometimes the complainant will be seeking a mixture of outcomes, or the decision made on their detention is only a small part of their complaint to us. In these circumstances we can decide part of the complaint is for the Tribunal and part is for us.

2.18 If we decide to close a case as it only relates to a decision to detain someone, and/or the outcome they want is to be released from detention then the case can be closed as 'reasonable to pursue an alternative legal remedy'[4]. **(Policy requirement)**

Complaints generally for the Local Government Ombudsman (LGO)

2.19 The LGO will consider any complaints where care and treatment has been provided by the local authority. An approved mental health professional who applies for a person to be detained under the MHA is acting on behalf of a local authority. Their actions are therefore for the LGO.

2.20 We will sometimes receive complaints that are partly for the LGO and partly for us. Where we identify this is the case, we must share the case with the LGO. **(Legal requirement)**

2.21 We have a joint working team, who work for the LGO, and consider cases which involve both NHS and local authority funded actions. All joint working

[4] Further information about alternative legal remedy is available from paragraph 2.154 of the Service Model main guidance.

cases must therefore be passed to them for their consideration[5]. **(Policy requirements)**

2.22 If we receive a case that only concerns the actions of the local authority then the local council can be added on MSD as the organisation to assess or investigate and the case can be closed as 'organisation out of jurisdiction.'**(Policy requirement)**

Complaints that can be considered by the Care Quality Commission (CQC)

2.23 We have a Memorandum of Understanding (MOU) with the CQC about how cases should be handled. It will not always be obvious whether us or the CQC is the most appropriate body to deal with a case relating to the MHA, and therefore the MOU should be referred to for further guidance. **(Policy requirement)**

2.24 The CQC has the responsibility for protecting a detained person's rights. There will therefore be areas of complaint that fall within the CQC's remit, but not our own, that directly relate to a person being detained. For example; we cannot consider the use of compulsory treatment orders or the decisions and/or actions of approved or responsible clinicians. These complaints should therefore be referred to the CQC. **(Policy requirement)**

2.25 If we cannot legally consider a case, but the CQC can, then the case should be closed as 'out of remit - other'. If we decide not to investigate a case as it is more suitable for the CQC to consider it then the case should be closed as 'other dispute resolution forum appropriate'. **(Policy requirements)**

[5] Further information about joint working is available from paragraph 1.41 of the Service Model main guidance.

3. The Victims' Code

What is the Victims' Code?

3.1 The Code of Practice for Victims of Crime (the Victims' Code) places a statutory obligation on criminal justice agencies to provide a standard of service to victims of crime or, where the victim died as a result of the criminal conduct, their relatives. A list of the organisations that have obligations under the Victims' Code is available at annex B.

3.2 The Victims' Code[6] was issued under section 32 of the *Domestic Violence, Crime and Victims Act 2004*, and came into effect in April 2006. A second version of the Victims' Code came into effect from 10 December 2013. An updated third version came into effect on 16 November 2015.

3.3 Any case that concerns an organisation's obligations under the Victims' Code should have 'Complaints about a breach of the Code of Practice for Victims' of crime' added as a theme. **(Policy requirement)**

Our jurisdiction in Victims' Code cases

3.4 Since 3 April 2006 we have had a statutory responsibility to consider complaints, referred by MPs, from members of the public who complain that an organisation has not met their obligations under the Victims' Code. The Victims' Code is not retrospective and the actions complained about must have occurred after 3 April 2006 or later, dependent on which version of the code was in place at the time.

3.5 We can still receive complaints that are covered by an older version of the Victims' Code. The caseworker considering the case must therefore make sure they are applying the right version when making a decision. **(Policy requirement)**

Complaints about organisations usually in our jurisdiction

3.6 If a complaint is made by an organisation that we can usually investigate anyway, we should consider it under both our normal jurisdiction and the organisation's obligations under the Victims' Code. If we want to make enquiries on a Victims' Code complaint with an organisation we can usually investigate, we should use the same contact details we use for any other case. **(Policy requirements)**

[6] Different versions of the Victims' Code are available in the E-library.

Complaints about organisations usually not in our jurisdiction

3.7 We only have jurisdiction over the Crown Prosecution Service (CPS) and the police in respect of Victims' Code complaints. We therefore must make sure that a complaint brought to us about these organisations concerns the Victims' Code before considering it further. If there is any uncertainty then the caseworker considering the case should speak to their manager or seek legal advice. **(Policy requirements)**

3.8 If a complaint about the CPS or the police is not one we are able to look at then we should consider telling the complainant about the Victims' Code so they can decide whether they have a complaint about it. The case can then be closed as 'organisation out of jurisdiction'. **(Policy requirements)**

Complaints about the police

3.9 If a case is about the police, and their obligations under the Victims' Code, then the organisation recorded on MSD should be the specific police force concerned. If the case does not concern an obligation under the Victims' Code then the police should be recorded as an 'OJ Public sector body'.**(Policy requirement)**

3.10 If a caseworker wants to make enquiries with a specific police force about a Victims' Code complaint, then they should contact the Professional Standards Department for the police force concerned. **(Policy requirement)**

Complaints about the Crown Prosecution Service

3.11 If a case is about the CPS, and their obligations under the Victims' Code, then they should be named as the organisation complained about on MSD. If the case does not concern an obligation under the Victims' Code then the CPS should be recorded as an 'OJ Public sector body'. **(Policy requirement)**

3.12 If a caseworker wants to contact the CPS then they should use the details of the focal point listed in our organisation contact list. (Policy requirement)

The Victims' Right to Review Scheme

3.13 The Victims' Right to Review Scheme allows victims to seek a review of a CPS decision to not bring charges or to terminate proceedings. It only applies to specific decisions made on or after 5 June 2013. A complainant should be

told about the option of pursuing a review through the scheme under the Victims' Code. We therefore could consider a complaint that this did not happen.

Assessing and investigating complaints made under the Victims' Code

3.14 We handle complaints about the Victims' Code similarly to our usual casework. There are some specific considerations we need to be aware of though when looking at these cases.

Contacting the complainant

3.15 A complaint made to us about the Victims' Code may often relate to a serious crime that may have had a big impact on the complainant's life. We therefore must be sensitive to the complainant's needs when making contact with them throughout a case.

3.16 The complainant may request we do not contact them on specific dates, for example the anniversary of a crime. The caseworker should respect the complainant's request and not make contact on these dates. **(Policy requirement)**

3.17 The caseworker should also record on MSD any dates when it may not be appropriate to make contact, even if not expressively requested. They should then avoid contacting the complainant on these dates. **(Policy requirements)**

3.18 The caseworker should consider any requests they receive from a complainant in relation to their contact preferences. These should then be recorded using the preferred method of contact tab on the complainant's MSD record and on the case. **(Policy requirement)**

Is the complaint ready for us?

3.19 The Victims' Code sets out an internal complaints procedure which it expects organisations it covers to follow. We would therefore expect complainants to put their complaints to the organisation concerned before bringing a case to us. **(Policy requirement)**

3.20 Complainants may not necessarily identify the correct, or all the correct, organisations they are complaining about (perhaps because they do not know who is responsible for what services). We should therefore make sure the

complainant has complained to the correct organisation before considering the case further.

3.21 We cannot assume though that all complainants are aware of the Victims' Code or their obligations under it. We therefore must be alert to the possibility that an agency covered by the Victims' Code may not be meeting their obligations under it. We should ensure complainants are made aware of the Victims' Code so they can make an informed decision if they want to pursue a complaint under it. **(Policy requirements)**

Is the complaint out of time?

3.22 In deciding whether to exercise our discretion and consider a complaint that is out of time we will usually consider the complainant's date of awareness to be when they first knew they could make a complaint under the Victims' Code. **(Policy requirement)**

Any other reason to investigate and investigation

3.23 In Victims Code cases, we don't refer to maladministration or service failure as we would do in the rest of our casework. Instead we look to see whether the organisation involved has '*performed a relevant duty*' (as set out in the Code) and we would frame our decision in those terms.

Providing an enhanced service

3.24 The Victims' Code was revised in 2013 and introduced an enhanced level of service for victims of the most serious crimes, vulnerable and/or intimidated victims and persistently targeted victims. We could therefore consider a complaint that an organisation who has responsibilities under the Victims' Code failed to recognise a victim of crime should have received an enhanced service or that this service wasn't fully provided.

4. Coroners and inquests

What is the role of the Coroner?

4.1 Coroners are independent judicial officers who are usually medically and legally trained. They investigate any violent, sudden, unexplained or unnatural death. Their statutory role is limited to determining the cause of death but has developed over the years to include monitoring the adequacy of surgical or other services.

4.2 A Coroner must hold an inquest if a cause of death is still unknown following a post-mortem, if the person potentially died a violent or unnatural death, or while they were in police custody.

4.3 The purpose of an inquest is to establish the identity of the deceased, when, where and how the death occurred and to establish the facts required so that the death can be registered. A Coroner can issue a verdict on its own or provide a narrative report if appropriate.

4.4 Coroners have a duty to make reports to a person, organisation, local authority or government department or agency when they consider action should be taken to prevent future deaths[7].

Challenging a decision made by a Coroner

4.5 We are unable to consider complaints about Coroners. A decision made by a Coroner, or the result of an inquest can only be challenged by an appeal to the courts by an application under section 13 of the *Coroners Act 1988*, or through judicial review. A complaint about the personal conduct of a Coroner can be considered by the Judicial Conduct Investigations Office, and then to the Judicial Appointments and Conduct Ombudsman.

Are Coroners an 'alternative remedy'?

4.6 A consideration of a case by a Coroner does not constitute an 'alternative legal remedy[8].' This is because certain deaths must be referred to a Coroner to determine the cause of death. Furthermore, the individual has no say in whether proceedings are initiated in the case of a Coroner's inquest. A complainant does not have the option to 'resort' or to have 'resorted' to a Coroner or inquest.

[7] Paragraph 7, Schedule 5 of the Coroner and Justice Act 2009
[8] Further information on alternative legal remedy is available from section 2.154 of the Service Model main guidance

4.7 We should consider, whether the findings of an inquest or a report to prevent future deaths provides an appropriate remedy for the complainant. In these instances we may consider the Coroner to be an alternative (non-legal) remedy. This will usually be because the outcome the complainant seeks is one that the inquest or the report that was provided was best placed to respond to. This could be because the complainant wants to know the cause of death or the Coroner has already issued a report to prevent future deaths that addresses the outcome the complainant is seeking.

4.8 The decision to close a case for this reason will be an exercise of our general discretion, and should be closed as 'other reason to decline.'

If an inquest is being held or due to be held in a case we are currently considering or investigating

4.9 There is no obligation for us to wait until a Coroner has reached a verdict before considering a case. We may decide it is appropriate to do so though, if the cause of death is one of the issues in dispute, or is an important aspect to other parts of the complaint.

4.10 If a case concerns an area of complaint that relates to the outcome of an inquest then we should usually close the case pending the result. Each case should be treated individually and there will be some circumstances where we still consider it is reasonable to continue our consideration of the case (for example, the complainant is terminally ill). In these instances the caseworker should get advice from their manager and consider consulting the Legal Team before proceeding. **(Policy requirements)**

<u>When we may decide to close a case pending the outcome of an inquest</u>

4.11 Circumstances when we may decide it is appropriate to close a case until the outcome of an inquest include:

- Where determining the cause of death is a key aspect of the complaint and not having the outcome of the inquest beforehand would impede our investigation or prevent us from delivering a quality decision.
- Where we cannot consider other aspects of the complaint without the outcome of an inquest. For example, those linked to the cause of death.
- Where running an investigation at the same time as the Coroner would be unfair or an unreasonable burden on a named person or organisation.

4.12 If, during an assessment, a caseworker considers a case should be closed pending the outcome of an inquest, then the closure code to use is 'other reason to decline'.

4.13 If, during an investigation, a caseworker considers we should stop work on a case until the inquest is complete, then the investigation should be closed as 'discontinued'. This should be completed in line with the normal approval processes set out in the Service Model main guidance[9].

4.14 The caseworker looking at the case should explain to the complainant that they can return to us following the inquest and we will then consider whether to investigate their case. At the same time they should explain our approach to the time limit[10] and manage the complainant's expectations that we may still decide not to investigate. **(Policy requirements)**

When we may decide to proceed before the outcome of an inquest

4.15 If we consider the case relates to the outcome of an inquest, then we can still decide to investigate those issues if appropriate. This could be for several reasons including:

- The case covers issues that cannot be attributable to the death, and therefore cannot be addressed by the Coroner. For example; staff rudeness.
- The outcome the complainant is seeking is not one the Coroner could rectify through the issuing of a report to prevent future deaths For example; a financial remedy.
- The complainant cannot achieve the outcome they want through an inquest. For example; questions relating to care or treatment received that do not link to the death, such as a complaint that a bed was uncomfortable.
- The Coroner's consideration (or inquest) is likely or has been set to take place at a date far into the future. In these instances we should consider if the delay may affect our ability to investigate the case and the impact a delay in us investigating would have on the complainant.

[9] Further information on discontinuing cases is available from section 5.33 of the Service Model main guidance
[10] Further information on our approach to the time limit is available from section 2.144 of the Service Model main guidance

Coroner and inquest cases at intake stage

4.16 If, during the course of considering a case, an Intake Caseworker becomes aware an inquest is ongoing or will be held then they should warn the complainant that this may prevent us from considering their case further at this time. **(Policy requirement)** The case can then either be closed or passed for assessment as required.

Can we investigate a case where an inquest has already been held?

4.17 We are able to investigate a case where the Coroner has already held an inquest. We should clearly manage the complainant's expectations though about what our investigation can achieve and the difference between our role and the Coroner's. **(Policy requirement)**

4.18 Our role is to look into complaints where someone has claimed to have experienced an injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right. We can then make findings, and if appropriate, recommendations.

4.19 The role of the Coroner is different as they can only make certain legal determinations, including the cause of death, for the purposes of allowing a death to be registered. The Coroner's verdict is a formal legal determination which our report cannot legally override and which remains in place for all purposes (for example, insurance, death certificates) unless overturned by a court.

Making different findings to the Coroner

4.20 We are not strictly bound by the findings of an inquest or a Coroner and there is nothing in our legislation to prevent us from making different findings. The Coroner has been specifically established though to determine the cause of death and will do so by cross examining witnesses in a public hearing, collecting statements and examining medical evidence.

4.21 If we decide to make different findings to the Coroner or inquest we must be able to demonstrate we had sufficient evidence to do so. This must be information the Coroner has not already seen or not had the opportunity to consider. We cannot make different findings purely on the basis that we prefer our view of the case. We must also be able to provide written reasons for why we have made a different decision if requested. **(Policy requirements)**

4.22 If during an investigation we decide we want to make findings that are different to the conclusions reached by a Coroner, then the Legal Team should be consulted for advice before we issue the draft report. **(Policy requirements)**

4.23 The Caseworker should also consider raising the risk rating on the case to high, given the potential risk to our reputation. The decision must then be agreed in accordance with our guidance on assessing risk[11] and the Delegation Scheme. **(Policy requirements)**

4.24 Any decision to make findings different to those made by a Coroner may lead to legal challenge. If we become aware a legal challenge is a possibility or receive any documents that suggest this is the case, the Legal Team must be contacted immediately. **(Policy requirement)**

Considering the outcome of an inquest in our assessment or investigation

4.25 Our role is different from that of the Coroner and we use and consider information differently to reach our conclusions. We therefore should not rely solely on the Coroner's findings to reach a decision on a case and should request all of our own evidence including clinical advice. **(Policy requirement)**

4.26 We can consider the Coroner's findings to inform how we may decide to progress a case. For example, if a Coroner's verdict or report suggests a failing on an organisation's part, then we may suggest this indicates service failure at assessment stage on that basis.

4.27 The Coroner has a duty to make reports when action could be taken to prevent future deaths. The Caseworker should therefore ascertain if the Coroner has already issued a report asking the organisation complained about to make improvements to their service and if so, establish if these have been taken forward. **(Policy requirement)**

If an inquest is held after our report has been issued

4.28 If we become aware an inquest is going to be held following our investigation of a case, then this should be raised with the manager of the caseworker who considered the case. If we become aware the findings of

[11] Further guidance about assessing risk in casework is available in section 1 of the Service Model general guidance

the inquest may differ from the results of our investigation then the Legal Team should be informed. **(Policy requirements)**

4.29 Our staff, including our clinical advisers, cannot be required to give evidence at an inquest of matters of which we became aware as part of our investigation of a complaint.

Receiving requests to disclose information to a Coroner

4.30 We can only provide information obtained for the purposes of an investigation directly to the Coroner in certain specified circumstances, the most relevant of which is where the information is to the effect that any person is likely to constitute a threat to the health and safety of patients[12]. We therefore must consider if information should be released for this reason if the Coroner requests it. **(Policy requirement)**

4.31 On occasion the Coroner may ask to see a copy of our final investigation report. We will usually not be able to release our report unless it is appropriate to do so. The Caseworker should therefore write to the Coroner and request an explanation to why this information is required. **(Policy requirement)** An example of sample wording is available in annex C of this document.

4.32 If the Caseworker who received the request needs further assistance they should seek advice from the Legal Team. **(Policy requirement)**

If the complainant wants to share the report

4.33 If a complainant wishes to pass a copy of our final report to a Coroner, then we should suggest they seek independent advice before they do so. We should ensure the complainant is aware that there are restrictions on sharing any information provided to them over the course of our investigation, and our draft report and that there are privacy and data protection implications for them to consider.

When Coroners refuse our request to provide information or evidence relevant to an investigation

4.34 On occasion the Coroner may refuse to provide us with information or evidence we need for our casework or ask for us to sign a waiver for its release. In these instances the Caseworker should write to the Coroner, to

[12] Further guidance about when we may decide to disclose information can be found in our disclosure of concerns about the health and safety of patients – section 15 health Service Commissioner's Act policy available in section 4 of the Service Model general guidance.

explain why it should be released. An example of sample wording is available in annex D of this document. **(Policy requirement)**

4.35 If the Caseworker continues to have difficulties securing the information or needs further assistance they should seek advice from the Legal Team. **(Policy requirement)**

5. Suspected criminal behaviour

5.1 If, during our consideration of a case, we find information that suggests that someone may have committed a criminal act, then the following steps should be taken **(policy requirements)**:

- Case risk rating reviewed[13].
- Case escalated through line management to Assistant Director for discussion (further escalation may be required).
- Advice sought from Legal Team.

5.2 This applies to actions by any party to the complaint, including complainants and organisations/individuals complained about. For example, we might see information that suggests that an individual has committed benefit fraud or that an organisation has falsified medical records.

5.3 Any action we decide to take will be based upon the specific circumstances of the case. This should usually be agreed first though, at Assistant Director level or above.

5.4 We should not approach any individual or organisation about the suspected criminal behaviour, unless it is agreed to do so as part of the escalation procedure set out in paragraph 5.1.

5.5 If the suspected criminal act is fraud, then reference should be made to the office's Fraud Response Plan.

5.6 We have a separate process for disclosing information where there is a risk to the health and safety of a complainant or others[14].

[13] Further guidance on risk is available in section 1 of the Service Model general guidance.
[14] Further guidance on disclosing information where there is a risk to the health and safety of others is available in section 4 of the Service Model general guidance.
Version: 4.0
Version date: 13/11/2017

Annex A - Which organisations have to provide services under the Victims' Code?

Organisations that have to provide services under the Victims' Code:

- The Criminal Cases Review Commission
- The Criminal Injuries Compensation Authority
- The Crown Prosecution Service (CPS)
- The First-tier Tribunal (Criminal Injuries Compensation)
- Her Majesty's Courts and Tribunals Service (HMCTS)
- Her Majesty's Prison Service
- National Offender Management Service (NOMS)
- The Parole Board
- Police and Crime Commissioners
- All police forces in England and Wales, the British Transport Police and the Ministry of Defence Police
- The National Probation Service
- The UK Supreme Court
- Witness Care Units
- Youth Offending Teams.

This Code requires the following organisations to provide services to victims in accordance with Chapter 5 of the Victims' Code only.

- The Competition and Markets Authority
- The Department for Business, Innovation and Skills (Criminal Enforcement)
- The Environment Agency
- The Financial Conduct Authority
- The Gambling Commission
- The Health and Safety Executive
- Her Majesty's Revenue and Customs
- Home Office (Immigration Enforcement)
- The Information Commissioner's Office
- The Independent Police Complaints Commission
- The National Crime Agency
- Natural Resources Wales
- The Office of Rail and Road
- The Serious Fraud Office.

Other organisations, including voluntary sector organisations, may provide victim support services for victims but they are not covered by this Code.

Annex B – Request for the Coroner to provide us with more information

We understand that the Coroner held an inquest into the death of **{name of deceased}** on **{relevant date}**. **{Details of person who contacted us}** subsequently contacted us and we have conducted a statutory investigation and produced a report. We further understand that **{person who has contacted the Coroner}** has provided you with a copy of that report and as a result, you have decided to hold a further inquest.

We understand you have contacted **{enter details}** and have asked them to supply you with further information about our investigation.

Our investigation in this case was conducted under the Health Service Commissioners Act 1993 (the HSCA). This requires that our investigations are carried out in private (11(2) HSCA).

The Ombudsman or those acting on her behalf can also not be required to give evidence in any proceedings (15(2) HSCA), including those of a Coroner, except in very limited circumstances detailed in section 15(1) of the HSCA.

Information we obtain is subject to a statutory prohibition on release (15(1) of the HSCA). This means we have no power to release information other than in limited circumstances referred to in the rest of section 15 of the HSCA. This includes sharing information when we think it is in the interests of the health and safety of patients.

At this time we consider we need further information from you before deciding if we can release information from our investigation. We would therefore appreciate it if you could confirm the circumstances of your request. We can then determine if our powers would allow us to make a voluntary disclosure to assist with your investigation.

Annex C - Request to sign a warning notice before evidence released

I understand that you have authorised the release of **{details of evidence requested}**, subject to us agreeing to sign a warning notice. We are not required to sign this warning notice and as a result of our own legislation are not restricted in how we may use the information we have requested.

We are not seeking **{details of evidence requested}** under regulation 27 of the Coroners (Investigations) Regulations 2013, so a warning in relation to section 9 of the Contempt of Court Act 1981 would not apply. We are requesting a copy of the recording under section 12 Health Service Commissioners Act 1993 ('the HSCA'), which grants us power to require *any* person, including a Coroner, to supply information that may be relevant to our investigation. The statutory exceptions to this provision are very limited and cover, for example, Cabinet minutes and information that could not be submitted in evidence to the High Court. The information we have requested would not fall within these exemptions and our power to obtain information is therefore not subject to the Coroners (Investigations) Regulations 2013.

Under section 15 of the HSCA, we are able to disclose information we obtain during an investigation for the purposes of the investigation or as part of a report of the investigation. Further, a report of the investigation is sent to the person who made the complaint, the NHS provider and the commissioner if the provider was not an NHS trust or foundation trust. We also have the power to send a report to regulators or other appropriate individuals or organisations, including coroners.

I can confirm that we will only use the recording requested to investigate the complaint about the care and treatment **{complainant's name]** has received and to write a report of that investigation. If appropriate, we will also give you the opportunity to comment on how any information from the recording is used in the report at draft stage.

As previously advised, although the Coroners (Inquests) Rules 2013 do not apply, we would be willing to pay a reasonable price to cover the costs of producing the information we have requested. In order to process such a payment, please provide an invoice and confirm the process for making a payment.