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Prisoner death investigations: improving safety in prisons and societies?

Summary of findings

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This work was supported by: UKRI Future Leaders Fellowship MR/T019085/1 (2020-24) and the: University of Nottingham Impact Prize (2019-20); Economic and Social Research Council Impact Accelerator Award (2020-21); University of Nottingham/ Research England Quality Research Strategic Priorities Funding (2021); University of Nottingham Institute for Policy and Engagement Small Grants (2021).

Dr Tomczak very gratefully acknowledges: Sue McAllister, who facilitated and supported this project; all the interview participants, who volunteered their time; co-authorship and research assistance from Dr Cathie Traynor, Dr Elizabeth Cook, Dr Rebecca Banwell-Moore, Dr Gill Buck, LUNG Theatre, Dr Lucy Wainwright, Dr Kaitlyn Quinn, Sara Hyde and Chloe Leak; and comments generously provided by Dr Sarah Leonard, Paula Harriott and Dr Nicola Carr.

Summary

Introduction

[Unsafe prisons mean unsafe societies](#). Prison suicides harm bereaved families, prisoners, prison staff and investigators. England and Wales experienced record prison suicide numbers in 2016, which cost the public an estimated £400 million. Prisoner death investigations offer opportunities to identify learning which could reduce harms and costs.

[Dr Philippa Tomczak's](#) team at the [University of Nottingham](#) have been analysing Prisons and Probation Ombudsman (PPO) death investigations in England and Wales since 2019. This analysis aimed to identify ways of reducing prisoner deaths and improving prison safety, for the benefit of prisons and societies. This work is driven by the necessity of humanely reducing prisoner deaths and associated wide-ranging harms. Our findings are particularly timely. The PPO has recently expanded to consider deaths after release from prison, which offers a window of opportunity to adapt practice based on our findings.

Following case law and its terms of reference, PPO findings must be mobilised to prevent prisoner deaths. PPO staff were motivated to reduce deaths. Yet, PPO death investigations are currently not fulfilling their harm reduction potential. By opening up to dialogue with academics and its stakeholders, the PPO is already paving the way to increase its impact.

Bereaved families

Formal death investigation processes risk subsuming the lived experiences of prisoners and bereaved families. Collaborative film offers a powerful form of visual representation, which can influence understanding. The short film WOODHILL produced by [LUNG theatre](#) features Janet Farrar, whose son Stephen died by suicide in HMP Woodhill in 2013. WOODHILL confronts us with the lived experience of bereavement by prison suicide and offers audiences an opportunity to (re)consider what forms of action are needed.

In our research, death investigators regularly invoked bereaved families to legitimise death investigations in their current forms. However, the 'satisfaction' of bereaved families with investigations was unknown and catharsis for families through investigation was readily assumed by investigators. The shortfall of impact and learning from death investigations means we lack evidence that legal 'lesson learning' provisions are being met.

PPO investigations

The PPO may inadvertently be 'doing more harm than good' at present. PPO investigations produce and compound vicious cycles of harm and blame across stakeholder groups, including its own staff, who could be greatly affected by deaths. Deaths and death investigations can have catastrophic effects on wellbeing. These harms must be mitigated.

PPO reports do not highlight the systemic hazards that mean 'accidents are waiting to happen' across the prison estate. Mental illness (including the remanding of people with very severe mental illness); drugs; large prisons; old, unsafe facilities; and inadequate staffing shape the likelihood of deaths, staff performance and prisoner experiences.

The PPO rely on attempts to 'fix' staff practices within individual prisons that are both highly likely to fail and misdirect responsibility. PPO silence regarding systemic hazards serves to perpetuate pressures in prisons. Staff in individual prisons have limited control over the systemic hazards that produce proneness to deaths. (Mis)directing responsibility to individual prisons means that central decision makers are both separated from the trauma of deaths and absolved of responsibility for their policies, which affect tens of thousands of prisoners, families and staff in England and Wales.

Seeking to 'fix' individual staff practices within individual prisons serves to blame them. Blame is problematic because it reduces openness in frontline staff and creates despondency across the PPO and all its stakeholders. A blame-free approach could complement the PPO's investigation methods. Statutory enforcement powers or 'teeth' for the PPO would exacerbate the problems of blame, and elide essential (re)consideration of what the PPO (does not) highlight, to whom, based on which evidence.

Overlapping PPO investigations and Coroners' inquests pose risks. There is currently little relationship between PPO and inquest findings. Inconsistent findings create confusion and mistrust. It is unclear whether the PPO's current remit enables it to fulfil its death prevention function, or has diverged sufficiently from predecessor Prison Service investigators. PPO reports have a problematic quasi-evidential, quasi-legal function. PPO investigators frequently ask leading questions and inquests often repeat the PPO's witness questioning, which is inefficient. Some Clinical Reviewers could not justify their conclusions. Coroners were keen to nurture earlier cooperation with the PPO.

Conclusion

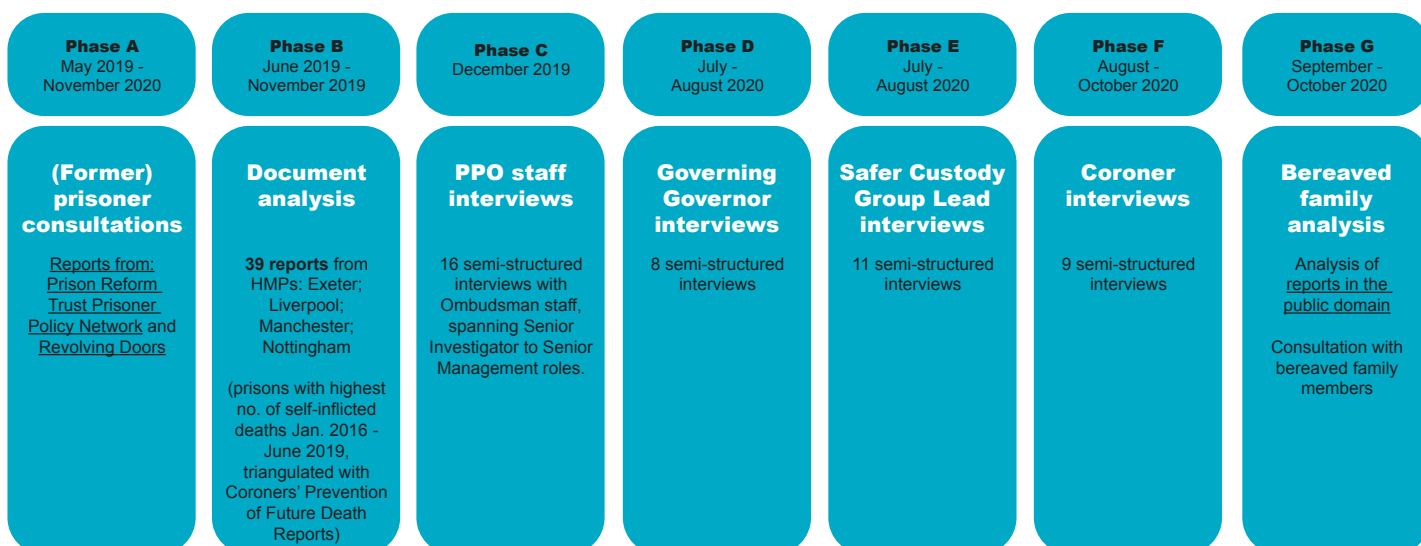
By adopting a broader systemic focus, rather than considering single deaths in single prisons, the PPO could support Coroners and other prison oversight bodies to make findings that encompass national problems (including mental illness; drugs; large prisons; inadequate staffing) and improve safety in prisons and societies.

All stakeholders are motivated to humanely reduce deaths, which offers a powerful springboard to support change. We look forward to seeing changes implemented in coming months.

Context

Dr Philippa Tomczak has been researching prison deaths and subsequent investigations since 2015. Dr Tomczak and [Sue McAllister](#) (the Prisons and Probation Ombudsman) met at a [Prison Reform Trust Prisoner Policy Network](#) event in January 2019. Sue McAllister was newly in post and seeking to increase PPO investigation impact. Both were concerned about enduring high numbers of prisoner deaths. Dr Tomczak led seven streams of data collection during 2019-20. The project involved collating and analysing a total of 45 stakeholder interviews and in excess of 70 documents. The team consulted with former prisoners, analysed PPO reports and interviewed: PPO staff; prison Governors; regional Prison Service Safer Custody Group Leads; Coroners and bereaved families. Ethical approval was granted by Her Majesty's Prison and Probation Service and the University of Nottingham. Data collection was undertaken by Dr Philippa Tomczak and Sara Hyde.

Figure 1: Phases of data collection



Reports and results from Phase A were presented in a public webinar in November 2019. Details are available [here](#). Since that webinar, the PPO have begun to check with the Prison Reform Trust about their potential contact with prisoners who went on to take their own lives, which feeds into death investigations where relevant. Further information is provided in *Appendix 1*.

Findings

i) The (untapped) potential of prison oversight

Prison health, prison safety and imprisonment rates matter both intrinsically and for health and safety outside, because [unsafe prisons mean unsafe societies](#).

Existing prison oversight apparatuses are extensive, including National Preventative Mechanisms (under OPCAT), death investigations and complaints. Together, these apparatuses hold substantive, yet largely unrealised harm reduction potential. The UK's 'blueprint' detention monitoring apparatuses have neither challenged high imprisonment rates (being outliers in Western Europe), nor mitigated recent dramatic declines in prison safety.

We have a limited evidence base illustrating what prison oversight actually achieves in practice. As such, all prison oversight bodies should both consider and make transparent the evidence base underpinning their activities, and their actual positive and negative impacts.

Substantive changes to the prison estate have been stimulated by the actions of bereaved families and voluntary organisations through (threatened) legal challenges. Statutory bodies are resourced to improve conditions of imprisonment but have had limited impact. Actors across sectors could advance issue-based prison regulation by working together and amplifying shared messages.

Supporting publication (free to access):

TOMCZAK P. (2021). [Reconceptualizing multisectoral prison regulation: Voluntary organisations and bereaved families as regulators](#). *Theoretical Criminology* OnlineFirst.

ii) Prisoner death investigations

PPO findings must be mobilised to prevent deaths, per legislation (Human Rights Act 1998), case law (*Amin: R v Secretary of State for the Home Department ex p Amin* [2003] UKHL 51) and the PPO's own terms of reference. It is unclear why the PPO does not sit on the UK's National Preventative Mechanism (under OPCAT). Ill-treatment often highlights the consequences of systemic hazards, hence should explicitly and directly inform preventative efforts.

PPO staff were motivated to reduce prisoner deaths and investigators could be greatly affected by repeated recommendations and continuing deaths, sometimes over long careers at the organisation. However, PPO death investigations have, for some years, been at an impasse, continuing to repeat recommendations with increasing fervour, without considering what the PPO (does not) highlight, to whom, based on which evidence.

Template recommendations on the PPO's recommendations database had received minimal attention, which represents a key area for evidence-based development. If seeking to prevent deaths, giving informal praise verbally to prison staff is a more powerful form of social control than blaming. Regulatory theory clearly demonstrates that when collectives are praised, all members want to share in the credit. When collectives are blamed, members tend to distance themselves from the adverse events. There is scope for the PPO to informally communicate praise to prison staff in order to better influence practice in prisons.

Supporting publication (free to access):

TOMCZAK P and MCALLISTER S. (2021). [Prisoner death investigations: a means for improving safety in prisons and societies?](#) *Journal of Social Welfare and Family Law* 43(2): 212-230.

iii) Film: Woodhill

Dedicated to the prisoners, families, friends and staff impacted by prison suicide

Formal death investigation processes risk subsuming the lived experiences of prisoners and their families. Trauma is often embodied and difficult to express in words. Collaborative film offers a powerful form of visual representation which can influence understanding and produce art with activist qualities. The short film WOODHILL features a bereaved mother, Janet Farrar, whose son Stephen died by suicide in HMP Woodhill in 2013. The words and experiences are Janet's. Professional writers, choreographers and musicians have added dramatic interpretations. WOODHILL confronts us with the lived experience of bereavement by prison suicide and invites audiences to (re)consider what actions are needed.

Janet's experience is not isolated. Between May 2013 and December 2016, 18 prisoners took their lives at HMP Woodhill, which combined multiple complex functions: a local prison, high security unit and close supervision centre for 'disruptive' prisoners. From 2013, staff cuts and shortages reduced regimes and time out of cell. Staff recruitment and retention at Woodhill was especially compromised by the cost of housing locally, and alternative jobs available in Milton Keynes and London. By 2017, Woodhill had functioned with restricted regimes for three years. Serious staff cuts and shortages led to boredom and isolation amongst prisoners, which are major contributing factors for self-harm. Suicide prevention policies were designed when the number of prison staff was significantly higher and the prisoner population significantly lower. Following suicide prevention procedures was therefore impossible in Woodhill. To prevent deaths of young men like Stephen, large prisons with insufficient staff and mental health resources must be subject to sustained challenge by interest groups working together.

Supporting materials (available on request: Alex.Elliott1@nottingham.ac.uk)



iv) Bereaved family ‘involvement’ in prisoner death investigations

Family involvement in death investigations may bear both substantial harms and benefits. Investigations can complicate, amplify and prolong families’ grief, but catharsis through investigation was frequently assumed. Bereaved families were regularly spoken about by PPO staff and Coroners, and invoked to legitimise prisoner death investigations in their current form, despite a lack of evidence that speaks directly to the ‘satisfaction’ of bereaved families.

The PPO must consider how families could be better prepared to receive draft and final investigation reports, which may be very upsetting, and the support services to which families could be signposted.

Following *Amin* (R v Secretary of State for the Home Department ex p *Amin* [2003] UKHL 51), a core purpose of death investigations is that bereaved families ‘have the satisfaction of knowing that lessons learned [...] may save the lives of others’. Due to the lack of impact and learning from death investigations, we lack evidence demonstrating that the provisions in Article 2 and case law (R v Secretary of State for the Home Department ex p *Amin* [2003] UKHL 51) are being met. If PPO investigations cannot or are unlikely to deliver impact in general, it is important that families are made aware of this to inform their specific decision to participate.

Legal provisions apply to all bereaved families, including those with varying (protected) characteristics (e.g. race, ethnicity, gender and disability). The PPO should seek both operational and perceived independence across its diverse bereaved family stakeholders.

Supporting publication (available on request: Alex.Elliott1@nottingham.ac.uk):

TOMCZAK P and COOK E, (*under review*) Bereaved family ‘involvement’ in (prisoner) death investigations: whose ‘satisfaction’?

v) The unacknowledged harms of prison suicides and investigations

Across stakeholder groups, there is universal desire to reduce prisoner suicides, but this ‘shared ground’ is not currently mobilised by death investigations, which may be inadvertently ‘doing more harm than good’. The harms of prisoner suicide and subsequent investigations are substantial and affect prisoners, bereaved families, prison staff and PPO investigators. Focusing on prison staff and PPO investigators in this section, the harms include: primary and vicarious trauma; prolonged and complicated grief; internalised responsibility; burn-out; and feelings of helplessness and powerlessness.

Although prisoner deaths are frequent, the harms of deaths and investigations are too little acknowledged or mitigated. Prison staff and PPO investigators were vulnerable to traumatisation, and described a cumulative ‘overload of death’. These harms significantly affect prison and PPO staff abilities to approach their work with dignity and humanity. Police investigations, sometimes stimulated by PPO investigations, led to months of stress for entire prisons and left a ‘lifelong impression’ on staff involved.

Death investigations direct responsibility for suicides towards staff in individual prisons. Governors, regional Safer Custody Group Leads and PPO investigators described feeling internalised personal responsibility for prisoner suicides. Internalising responsibility can have a catastrophic effect on wellbeing. The PPO must clarify how it will avoid and mitigate these harms.

Supporting publication (available on request: Alex.Elliott1@nottingham.ac.uk):

BANWELL-MOORE R, TOMCZAK P, WAINWRIGHT L, TRAYNOR C and HYDE S, (*under review*) ‘The Human Toll’: Highlighting the unacknowledged harms of prison suicide which radiate across stakeholders.

vi) Silence on ‘accidents waiting to happen’ systemically

The PPO currently undertakes narrow, individualised death investigations, producing simple explanations for failures in complex prison systems. This approach problematically assumes that prisoner deaths will decline if ‘bad apple’ staff are identified and/or imperfect practices corrected, without further structural changes to policy or practice.

PPO investigations frequently repeat critiques and recommendations. However, the PPO do not highlight the ‘accidents waiting to happen’ that are present across the prison estate. Mental illness; drugs; old, unsafe facilities; large prisons; and inadequate staffing shape the likelihood of deaths, staff performance and prisoner experiences nationally. The PPO’s silence regarding these systemic hazards serves to perpetuate pressures in prisons, whilst relying on attempts to ‘fix’ individual staff practice that are highly likely to fail.

Death investigations direct responsibility for suicides towards staff in individual prisons, who have limited control over the systemic hazards that produce proneness to deaths. Central decision makers are both separated from the trauma of deaths and absolved of responsibility for their policies, which affect tens of thousands of prisoners, families and staff every day in England and Wales.

Supporting publication (available on request: Alex.Elliott1@nottingham.ac.uk):

TOMCZAK P, QUINN K, TRAYNOR C, WAINWRIGHT L and HYDE S, (*under review*) Silence on contextual hazards in prisoner death investigations: “maybe we should be aiming our canons a bit higher rather than constantly telling off staff on the units who are doing the best they can”.

vii) Prisoner death investigations: challenging the remand of people with very severe mental illness?

Remanding people with very severe acute mental illness to prison (sometimes ‘for their own protection’) culminated in at least four self-inflicted deaths in prison between January 2016 and April 2017. Lewis Francis, Jason Basalat, Dean Saunders and Sarah Reed were acutely and severely unwell at the time of their alleged offence and remand. Their deaths harmed bereaved family members and affected other prisoners, who potentially witnessed and/or were bereaved by the deaths, and/or experienced disrupted regimes through staff being diverted to death investigations. Prison staff too were affected by managing people with very severe mental illness whom they were not trained, equipped, supported or resourced to assist.

People with psychosis and delusions are at increased risk of suicide. The PPO must transparently demonstrate the basis upon which it judges their deaths to be unpredictable or unpreventable. The PPO investigations into these deaths did not highlight the remanding of people with very severe acute mental illness to prison, although all Coroners subsequently did so. This suggests that, despite rhetorical ‘independence’ and wide-ranging aims, the PPO has perhaps diverged insufficiently from the practices of their predecessor Prison Service investigators (who investigated deaths until 2004). The PPO should reconsider the (lack of) relationship between their recommendations and those made by Coroners, and consider whether its remit is currently broad enough to fulfil its death prevention function.

Supporting publication (available on request: Alex.Elliott1@nottingham.ac.uk):

TOMCZAK P, (*in progress*) Learning from prisoner death investigations: challenging the remand of people with very severe mental illness?

viii) Blame in prisoner death investigations

Blame is rife in prisoner (death) investigations. The PPO currently directs responsibility towards prison managers and staff for failing to prevent deaths, either through procedural mistakes, lack of co-operation, neglecting to apply its recommendations, or apathy.

Blame is problematic because indignation, frustration and fear reduce openness in frontline staff and create despondency across the PPO and all its stakeholders. This contributes to the enduring elevated numbers of deaths. Indignation, frustration and fear are fuelled by PPO reports which currently lack: empathy; praise; and acknowledgement of contextual hazards, and principally examine deaths within individual prisons.

Blame can be mitigated by approaching investigations differently. Focussing on fact-finding invites blame because it highlights the role of frontline staff in relation to specific deaths in custody. Future investigations must involve alternative methods of analysis to alleviate this problem. Further dialogue with stakeholders offers ways to understand and address reasons for prison suicide that are blame-free. Statutory enforcement powers or 'teeth' for the PPO would exacerbate the problems of blame, and elide essential consideration of what the PPO (does not) highlight, to whom, based on which evidence.

Supporting publication (available on request: Alex.Elliott1@nottingham.ac.uk):

TRAYNOR C and TOMCZAK P, (*in progress*) Beyond blame in (prisoner) death investigations.

ix) Coroners' perspectives on PPO death investigations

PPO investigations provide a 'starting point' for inquests, helping Coroners to navigate prison files and signpost issues. However, the overlapping PPO investigation and inquest posed risks. The PPO made recommendations that were not directly linked to deaths. The potential for numerous PPO recommendations followed by a Coroner's Prevention of Future Death Report risked actions 'being lost in a long list'. Inconsistent outcomes also risked creating confusion for the services and bereaved families involved. Simultaneously, the PPO did not consider factors that were central to deaths, e.g. how drugs enter prisons. The PPO could reconsider and clarify their terms of reference and remit, making reference to Coronial remits.

PPO reports currently have a problematic quasi-evidential, quasi-legal function. It is unclear whether witnesses understand that their accounts may be probed in subsequent Coronial and even criminal investigations. This is particularly problematic because PPO investigators frequently ask leading questions. Inquests often repeat the PPO's questioning of witnesses, which is inefficient. Clinical reviewers had inappropriate expertise and too frequently could not justify their conclusions and recommendations, which were incorporated into PPO reports. Inadequate clinical expertise could create delays in the inquest, e.g. if reports had to be repeated or recommissioned, in turn affecting Coroners' service to bereaved families. Coroners were keen to nurture earlier engagement and cooperation with the PPO. By adopting a broader focus, rather than single deaths in single prisons, the PPO could support Coroners to make findings that encompass national problems.

Supporting publication (available on request: Alex.Elliott1@nottingham.ac.uk):

TOMCZAK P, (*in progress*) Coroners' perspectives on PPO death investigations.

Appendix 1

Reports and results from Phase A were presented in a public webinar in November 2019. Details are available [here](#).

Phase B entailed document analysis of a sample of 39 fatal incident investigation reports. These were the reports available from the prisons with the estate's highest number of self-inflicted deaths between January 2016 and June 2019: HMPs Exeter, Leeds, Manchester and Nottingham. This analysis was triangulated with information from [Coroner's Prevention of Future Death](#) reports and prison [Independent Monitoring Board](#) reports.

Phase C entailed 16 semi-structured interviews with PPO staff spanning Senior Investigator to Senior Management roles. PPO staff volunteered to participate following a purposive email invitation to all Band A and B staff. Face to face interviews were carried out by Philippa Tomczak and Sara Hyde in December 2019. Ethical approval was obtained from the University of Nottingham.

Phase D entailed eight semi-structured interviews with prison Governing Governors in England, who volunteered to participate following an email invitation sent to prisons that had recently experienced multiple suicides. Virtual interviews were carried out by Sara Hyde in Summer 2020.

Phase E entailed 11 semi-structured interviews with regional Safer Custody Group Leads (SCGLs), who volunteered to participate following an email invitation sent to all SCGLs in England and Wales. Virtual interviews were carried out by Sara Hyde in Summer 2020. SCGLs provide regional support to prisons on improving safer custody (reducing deaths, self-harm and violence) by identifying and sharing good practice and learning from serious incidents.

Phase F entailed 9 semi-structured interviews with Coroners, who volunteered to participate following an email invitation sent to all area Coroners. Virtual interviews were carried out by Sara Hyde in Summer 2020.

Phase G entailed a semi-structured interview with a bereaved family member, undertaken virtually by Sara Hyde in Summer 2020. In our study, bereaved family recruitment was constrained by multiple factors. The PPO did not want to contact its list of bereaved families regarding this research due to the sensitivity of the inquiry. In addition to: the paucity of existing theory and data which could inform ethical qualitative research, the sensitive and potentially stigmatising topic, the need to limit participation to cases where inquests had concluded, extensive constraints amidst COVID-19 and the emergence of this theme during this research project; we did not have capacity to undertake further participants. We supplemented our original account with secondary data, including the account of Stella ([from Tomczak, 2018](#)); research reported by INQUEST ([2010, 2014, 2018, 2019](#)) and the Harris Review ([2015](#)).

All interviews were audio-recorded with participant's consent. Data have been anonymised.

All fatal incident reports and interview transcripts were thematically coded and analysed in Word, utilising ethnographic content analysis (ECA). Unlike positivist document analysis, ECA conceptualises document analysis as fieldwork. ECA entails discovery of analytical themes and sustained reflexivity about the research process and document production processes. Reflexive and recursive movement between concept development–sampling–data collection–data coding–data analysis–interpretation provides a systematic approach, whilst retaining flexibility to (re)develop analytical categories. This flexibility can enable novel findings and step-changes in analysis, facilitating important implications for practice.



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Published October 2021.

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