



29<sup>th</sup> September 2020

**WRITTEN SUBMISSION: Strengthening the Independent Scrutiny Bodies through Legislation**

1. I am currently a Nottingham Research Fellow. From 1<sup>st</sup> November 2020 I will be a [UK Research and Innovation Future Leaders Fellow](#) examining *Prison Regulation, for Safer Societies*. In 2021 I commence a [European Research Council Starting Grant](#) on *Regulating Criminal Justice Detention*.
2. This submission is based upon my prisons and punishment research, particularly my ongoing research with the Prisons and Probation Ombudsman (PPO) regarding the impact of PPO recommendations. I have been researching prison suicide since 2015. I have published [two books and multiple peer-reviewed journal articles](#). My 2018 [book provided the first account](#) of the Police, Ombudsman and Coroner investigations that follow prison suicide/self-inflicted death. My 2017 [book conceptualised the penal voluntary sector](#), winning the *British Society of Criminology* book prize. My research has been funded by the European Research Council, UK Research and Innovation, the Leverhulme Trust, the British Academy, the ESRC Impact Accelerator and the Universities of Manchester, Nottingham and Sheffield.
3. I have commented only on the parts of the consultation where I have particular expertise. My particular expertise relates to the roles of the PPO and Coroners in investigating prisoner deaths.
4. Statutory status for the PPO has been mooted for some years now. **Statutory status will not automatically translate into improved independence, credibility and effectiveness.** Judicially affirmed rights are not self-implementing and the symbolic presence of legal structures does not equate to compliance (Edelman 2016). I note that Coroners enjoy relative legal 'teeth', yet can find limited evidence that their Regulation 28 Reports are any more effective than the PPO at influencing practice and safeguarding (e.g. Mendas, 2012). Whilst the PPO may sometimes encounter difficulties



with document production and/or securing witness testimony, I believe their lack of statutory status is not the most significant factor affecting the PPO's credibility and effectiveness. Significant considerations are the **lack of attention to forwards facing/preventative work** in primarily backwards facing death investigations, and **the lack of consideration given to what the PPO recommend** as a result of their investigations. This has implications across detention oversight bodies.

5. The parameters for an Article 2 investigation parameters are primarily backwards facing. However, the House of Lords in Amin identifies the purpose of investigation under Article 2 thus (in Richards 2007, p. 3, emphasis added):

to ensure so far as possible that the full facts are brought to light, that culpable and discreditable conduct is exposed and brought to public notice, that suspicion of deliberate wrongdoing if unjustified is allayed, that dangerous practices and procedures are rectified, and that those who have lost their relative may at least have the satisfaction of knowing that *lessons learned from his death may save the lives of others*.
6. By its own analysis, the PPO struggles to effect change:

In 2018/19 we began 334 fatal incident investigations. [...] We saw a 23% increase in self-inflicted deaths this year with worryingly high numbers in some prisons. In many cases, we had to make the *same recommendations as in previous years, where remedial action had been promised* (PPO 2019, p. 11, emphasis added).
7. A problematic yet oft-reproduced assumption is that investigations fail to facilitate policy and organizational reform simply because their recommendations are not implemented. However, I question the **substance of investigators' recommendations**.
8. Despite the primarily backwards-facing legislative basis for their investigations, PPO staff are invested in preventing prisoner deaths. Yet, consistently repeated recommendations indicate that PPO investigations do not reduce prisons' vulnerability to future deaths and potentially establish a vicious cycle by demoralising PPO staff, which has implications for their wellbeing, productivity (Kalra et al. 2016), and motivation to invest in long-term, strategic thinking and/or attempts to adapt practice.
9. The PPO use a recommendations database to make sense of their findings and suggest action for the future. This database was apparently established between five and 10 years ago due to a drive for consistency. However, template



recommendations on the database have received minimal attention and the PPO continue to make the same recommendations, despite their apparent lack of efficacy.

10. This is a substantive problem affecting prison oversight around the world. There is a surprisingly limited research base to inform prison oversight (Padfield, 2018; Hardwick and Murray 2019; Rogan 2019). Beyond individual expertise, there is no guidance available to direct or facilitate evidence-based recommendations, despite the ubiquity of recommendations as a prison oversight tool. To my knowledge, nobody has yet developed an evidence base to guide how recommendations should flow from investigation and inspection findings. This is a significant gap globally. National Preventative Mechanism (NPM) members are mandated to produce reports following their visits, which should, when appropriate 'contain recommendations addressed to the relevant authorities' (UN 2010, p. 3). Because the PPO is 'wholly independent' from the authorities in its remit, it is apparently equipped 'to execute fair and impartial investigations, making recommendations for change where necessary, without fear or favour' (PPO 2017, p. 1). Developing evidence-based, forward-facing recommendations for use by prison oversight bodies is an essential yet complicated task. Statutory status for the PPO will not translate into more informed recommendations, the PPO need to be equipped to make better sense of the information they obtain and make evidence based recommendations.
11. I was not clear why only IMBs need to be equipped to recognise good practice. I would argue that the Ombudsman should also do this.

Many thanks for your consideration. Of course I am more than happy to expand if useful.

Yours,

A handwritten signature in black ink, appearing to read 'Philippa Tomczak'.

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