Contextual Hazards

Reflections from Governors and SCGLs of Fatal Incident Reports

Why contextual hazards?

Deaths in custody do not happen in a vacuum. Rather they are the result of multiple, interconnecting factors.

Concern that the PPO does not see the big picture and focuses "*narrowly on the how (factual circumstances) of each death, rather than the broader question of why*" (Aitken 2021: 17)

In doing so, this can neglect the very real influence of contextual hazards

Contextual hazards are:

- The predisposing events which create proneness to failure, weaknesses
- Likely to be present in the organisation long before any fatal incident

In fact, it is said to be "impossible" to adequately account for human error without considering contextual system issues, because the performance of prison staff will be fundamentally shaped by local workplace conditions and wider organisational factors

We concentrate on 3 primary contextual hazards, which may contribute to discussion of Aitken's question; 'why?'

- Severe mental ill-health
- Unsafe facilities
- Staff shortages

Contextual Hazard 1

Severe mental ill-health

Central to longstanding debate over who should be treated and who should be punished (Seddon, 2007).

> *GOVERNOR 2: The last two deaths in custody I've had, both of those guys were hearing voices, both of those had bizarre behaviour, both in my view should never have been in custody in the first place.*

The costs of 'misplaced' patients in the criminal justice system are no secret e.g. the 1992 Reed Report & the 2009 Bradley Report. Governors and SCGLs were concerned prisons were seen as safe places to send people with serious mental health needs.

> *GOVERNOR 4: Magistrates, […] they see prison as a place of safety. Prison is not a place of safety.*

Participants refer to safety in different ways - for prisoners as well as staff, and from others as well as from themselves.

Instead of being places of safety, prisons are noisy, busy, and strained environments, where the vulnerable can become more vulnerable.

Contextual Hazard 1

Severe mental ill-health

The (increasing) complexity of need seen was stressed in interview.

Relatedly, it was also stressed how prison staff are not trained to manage people with such severe mental illness. While mental health in-reach services are available, these are often only available in office hours.

At a fundamental level, there was frustration that investigations did not consider whether prisoners were *reasonably located* in penal settings, or also whether resource was available, yet placed blame on prison staff for deaths of individuals with severe mental illness.

> *SCGL2: I had a prisoner who I was really, really fearful would take their life and actually the establishment had been trying tirelessly to get her moved to where she needed to be, which was not in prison and it was an ongoing battle. They did so much work, they kept her alive, […] if she is successful and takes her life none of that will be taken into consideration*

As they stand, Fatal Incident Reports are seen as a lost opportunity in terms of igniting the debate about who should be in prison / hospital – as well as exploring the resource / training needed in relation to mental health if we are to avoid future deaths.

Contextual Hazard 2

Unsafe (unfit) facilities

Safety must be balanced with humanity and quality of life in prison, and to this end safer cells form only a small proportion of cells in the estate (Gunnell et al, 2005).

However, Governors cited Victorian prison buildings including ‘loads of ligature points’ as an accident waiting to happen.

> *GOVERNOR 5: It's a very challenging environment, […] one of the things I always think of when I think about the place, does it need pulling down? You know, it isn’t fit for purpose, you know, it's [over 100] years old and showing every sign of that really.*

In addition, Governors referred to the lack of provision within the prisons and feel this should form part of the recommendations made.

> *GOVERNOR 7: Rather than: ‘the governor should send out a notice to staff reminding them that they should use Code Red and Code Blue appropriately’. […] At the end of the day, what I actually need is the furniture, the anti-ligature. […] In our case here […] they are […] serving 30 years, actually my job […]It's about how to keep them alive for 30 years […] I don’t have any real workshops, I don’t have any space to build anything and […] I haven’t got any money […].*

Contextual Hazard 3

Staff shortages

Governors highlighted that staffing was extremely problematic as a result of national benchmarking measures to cut staffing costs. Benchmarking correlated with increased suicide (Tomczak, 2018).

Staff shortages affect the ability to react to prisoner needs.

> *GOVERNOR 4: There were 3,000 emergency cell bells that day, there was only one member of staff. […] Just to contextualise [this], rather than just this is what happened. […] It just feels very clinical without any context.*

There were said to be unreasonable expectations that operational staff should all be psychologists as well as perform operational duties. Governors suggested that the PPO could deliver or recommend suicide and self-harm training for staff at entry and 'refresher' level.

Again, it was considered that PPO reports are an opportunity (currently unmet) for change. One Governor suggested that through their reports, the PPO could place deaths in context as well as highlight staffing inadequacies / challenge central decision makers:

> GOVERNOR 2: *You can't say every prisoner must be seen by a member of Healthcare before being put on a constant watch, if there's no Healthcare in the Prison. Maybe the Ombudsman […] should say HMPPS, you should have a Nurse on duty 24 hours a day.*

Why important?

We believe there is potential in Fatal Incident Reports to do more than they are doing in preventing future death. This is shared by Governors and SCGLs.

Currently the PPO's attention is focused at the very sharp end of the spectrum of activities - rather like the pin that causes an over inflated balloon to burst (Blockley, 1992). In the balloon analogy, it is accepted that everything going into that balloon will contribute to its eventual popping.

Management decisions that remove (some of) the predisposing events which create the accidents waiting to happen therefore reduce likelihood of failure (or let air out of the balloon).

However, this requires actors to spot and name the accidents waiting to happen and then take action to manage away the problems.

By identifying the role of contextual hazards in prisoner deaths, and applying some pressure to remedy them, is deemed an important role for the PPO.

Without this recognition, we face a vicious cycle of frustration and the risk of inaction.