prisonHEALTH
PRISONS, HEALTH AND SOCIETIES RESEARCH

UKRI

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Prisoner Death Investigations

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Longstanding interest in (untapped) potential of prison oversight

Existing prison regulation apparatuses are extensive and hold substantive, yet unrealized potential to (re)shape imprisonment.

SCALES	STATUTORY PRISON REGULATION	VOLUNTARY SECTOR REGULATION	FAMILIES	COURTS	PRISONERS
LOCAL	Independent Monitoring Board	(e.g. Local Communities Against Prison Expansion, OUT THERE)			
NATIONAL	Inspectorate, Ombudsmen, Coroner	INQUEST, Prison Reform Trust (Howard League, Women in Prison, Zahid Mubarek Trust)			
REGIONAL	European Committee for the Prevention of Torture	(e.g. European Prison Observatory)			
INTER-NATIONAL	UN Subcommittee for the Prevention of Torture; UN Human Rights Committee	(e.g. Human Rights Watch, Amnesty International, Penal Reform International)			

Engaging more imaginatively and expansively with prison oversight in theory and practice could form a productive means for scholars, oversight bodies and community partners to *do more* than documenting the harms of mass incarceration, and thereby map a more optimistic, socially beneficial way ahead (Tomczak, 2021).

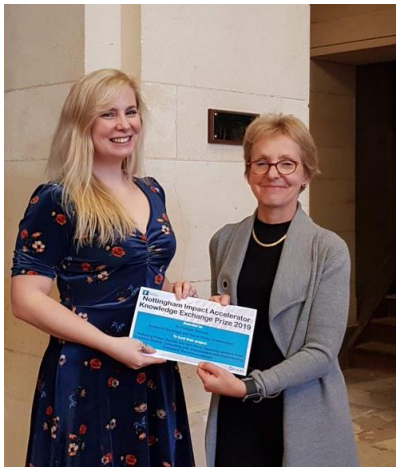
TEAM EFFORT

PRISONER
POLICY
NETWORK

PRISON **REFORM** TRUST

IMPACT ACCELERATION ACCOUNT (IAA)

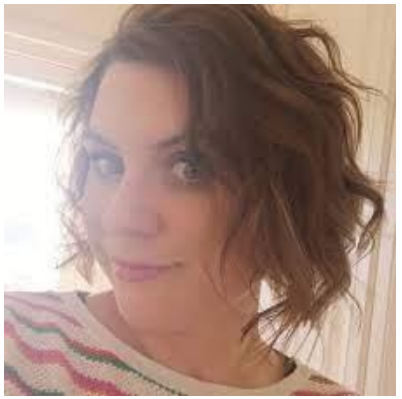
UKRI Economic and Social Research Council



Globally unique dataset collected (amidst the pandemic and moratorium…)

Phase A May 2019 - November 2020	Phase B June 2019 – November 2019	Phase C December 2019	Phase D July – August 2020	Phase E July – August 2020	Phase F August - October 2020	Phase G September - October 2020
(Former) prisoner consultations Reports from: Prison Reform Trust Prisoner Policy Network; Revolving Doors	**Document analysis** 39 reports: HMPs Exeter, Liverpool, Manchester, Nottingham (prisons with highest no. of self-inflicted deaths Jan. 2016 - June 2019; triangulated with Coroners' Prevention of Future Death reports)	**PPO staff interviews** 16 semi-structured interviews with Ombudsman staff, spanning Senior Investigator to Senior Management roles	**Governing Governor interviews** 8 semi-structured interviews	**Safer Custody Group Lead interviews** 11 semi-structured interviews	**Coroner interviews** 9 semi-structured interviews	**Bereaved family analysis** Analysis of reports in the public domain Consultation with bereaved family members

TEAM PPO BRIEFING PAPERS



	BRIEFING	ARTICLE
1	TOMCZAK P (2021) *The untapped potential of prison oversight*	TOMCZAK P (2021) Reconceptualizing multisectoral prison regulation: Voluntary organisations and bereaved families as regulators *Theoretical Criminology*
2	TOMCZAK P (2021) *The untapped harm reduction potential of prisoner death investigations*	TOMCZAK P, McALLISTER S (2021) Prisoner death investigations: a means for improving safety in prisons and societies? *Journal of Social Welfare and Family Law* PPO '*The Investigator*' newsletter
3	TOMCZAK P (2021) *Criminalising severe mental illness: inappropriate imprisonment as a contextual hazard*	TOMCZAK P (under review) Learning from prison suicide investigations? Remanding people with severe mental illness. *European Journal of Criminology*
4	TOMCZAK P, TRAYNOR C, WAINWRIGHT L, HYDE S (2021) *Naming contextual hazards to prevent prison suicide*	TOMCZAK P, TRAYNOR C, WAINWRIGHT L, HYDE S (under review) Naming contextual hazards to prevent (prison) suicide: 'I think that should be better, bearing in mind it is 2020'. *Critical Social Policy*
5	TRAYNOR C, WAINWRIGHT L, TOMCZAK P, HYDE S *PPO death investigations and stakeholder alienation*	
6	Legal and evidence base for multiple investigations Harms (RBM/ LW). Families (EC).	

Time, space, scale

- How do/ could the inquiries and investigations of the past inform the present and future of imprisonment?

- How do/ could siloed regulators with particular remits engage with the institutions that feed prisons?

- How do/ could regulators engage with individual and systemic problems? -> currently focus on individual staff and individual prisons yet we often see similar problems across the estate

2: Untapped harm reduction potential of prisoner death investigations

It is unclear why the PPO does not sit on the UK's OPCAT National Preventative Mechanism.

Amin and the PPO's terms of reference require that the PPO seek to mobilise their findings to prevent future deaths. However, the PPO struggle to effect change in practice.

Data from interviews with PPO staff, prison Governors and Safer Custody Group Leads, demonstrate: i) shared, powerful motivation to prevent prisoner deaths across stakeholder groups; ii) stakeholder agreement on the importance of prisoner death investigations; iii) stakeholder consensus that PPO investigations do not currently achieve enough overall.

PPO death investigations are currently 'missing the mark': failing to fulfil their harm reduction potential and potentially producing vicious cycles of demotivation and alienation. There is a limited evidence base to inform death investigation and subsequent recommendations and a need to reflect upon (potential) negative implications of oversight.

3: Learning from prison suicide investigations? Remanding people with severe mental illness

An oft-reproduced assumption is that investigations fail to facilitate policy and organizational reform simply *because their recommendations are not implemented* (Coles and Shaw, 2012; PPO, 2019). However, this apparent 'problem of implementation' has elided essential consideration of *what is recommended, based on which evidence*, such that there has been barely any scholarly engagement with what prison oversight bodies find and recommend in practice. Principled considerations, such as the independence of oversight bodies, have been slightly more prominent.

Troubling self-inflicted deaths/suicides involving people with severe mental illness, *to the extent of lacking capacity to engage with the criminal justice system*, at the time of their alleged offence and remand to prison.

Mr Lewis Francis (d. 24/4/2017, HMP Exeter); Mr Jason Basalat (d. 11/12/2016, HMP Woodhill); Ms Sarah Reed (d. 11/1/2016, HMP Holloway); Mr Dean Saunders (d. 4/1/2016, HMP Chelmsford)

PPO don't engage with this: 'remit' – problematic for families? Inquests do better but misdirect.

Questions

1. I've written this up with purely documentary analysis data in a straight 'criminological' way.

I remain deeply troubled by the use of remand for those with acute psychosis/lacking mental capacity and CPS guidance that 'some offences are too serious for diversion'. Intersection between law, liaison and diversion, public health and philosophy.

These folks can't participate and probably have no voice. I feel this argument needs to be made to other disciplines. Happy to share the article I have under consideration and I invite any alternative angles I/we/you could potentially pursue.

Mens rea. Doli incapax…

Time, space, scale: is this conceptually useful?

- How do/ could the inquiries and investigations of the past inform the present and future of imprisonment?

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