PPO Death Investigations and Stakeholder Alienation

How does this backward-facing mechanism create alienation (and challenging relationships) between the PPO, Governors and Safer Custody Group Leads?

Ignoring contextual hazards causes deaths

- Directly through failing to *name* severe mental ill health; unsafe facilities; staffing inadequacies

- Indirectly through alienation and challenging relationships between those that investigate and try to prevent them (PPO, Governors, SCGLs)

- Alienation & challenging relationships create and are perpetuated by defensiveness and blame

Alienation

- “World is given and beyond their control - they feel themselves unable to act meaningfully” Skotnicki and Nielson 2021:6; Jaeggi 2014)

- “A deficient relationship to the future in which people’s senses of possibility ossify, narrow or dissipate” (Skotnicki and Nielson 2021: 1)

Governor 5: There was no appreciation of the context of which this man had been looked after, the support he got […] It was an offence he couldn’t live with […] It was a really tragic case, it affected us all massively and […] the PPO report just turned me off completely, the whole context was entirely critical, so it had no impact on me other than to piss me off. When you read a report that says ‘This is rubbish, and this time I’ve written to the Governor […] about this and he’s clearly not bloody listening’ you know, you just think - Well sod you then!

The PPO's alienation

- PPO staff strongly protect their decision *not to* include contextual hazards in reports.

PPO 6: We can never excuse things by saying 'They didn't do this, but they are really short staffed' […] Yes that might be true, it might not be true, who knows […] It's really hard to work out how accurate the resourcing issue is in terms of this particular prisoner's death, but […] we are not allowed to use that as kind of an excuse […] because you could excuse anything that happens on that basis

- Also relates to establishments not appearing to learn from the repeated mistakes the PPO identifies, relating to policy and processes.

PPO 2: Some prisons […] just nothing changes, […] they just pay […] us, our reports and recommendations, almost lip service. […] It can be fairly soul-destroying […] when you have made recommendations and […] you hear that the same situation has happened and they are just not learning, so you can be quite despondent. […] I'm not sure it achieves a massive amount in some of the bigger prisons because *we do keep saying the same things again and again and again* (emphasis added)

Governing Governors & Staff

- Governors feel the PPO focuses on mistakes at establishment level. Their sense of alienation and being blamed 'at the sharp end' means they emphasise what they can't solve. This is not as an excuse but because they want the PPO to support them in addressing contextual hazards; the complexity of identifying suicide risk; and human instinct.

Governor 4: I defy anybody to be able to say this is how I would react if I found a prisoner hanging, while we are sat here, and say well of course I would ring and call a Code Blue or Code Red because I know all that but when you see a body for the first time, *I defy anybody to say 'Oh I would follow it to the letter' (emphasis added)*

Safer Custody Group Leads' alienation

- The SCGLs alienation involves feeling like a middle (wo)man, irrelevant or thwarted, in their efforts to promote learning. They clash with protective governors *and* struggle with the PPO, whose report recommendations are slow, or instill fear by naming custodial staff.

SCGL 8: I see no merit in that staff being singled out in a recommendation [...] That's why staff have such negative perceptions of the PPO because if I was a family member and I saw a named member of staff, I would want that man's head, or that woman's head and say you failed my loved one. That's a really awful decision to put our staff in.

Towards a “Just Culture” when things go wrong

- How do you foster control, meaningfulness and future possibility and address vicious cycles of defensiveness and blame to prevent self-inflicted deaths?
- Dekker 2017: If professionals consider one thing “unjust” it is often this: split second operational decisions that get evaluated, turned over, examined, picked apart, and analysed for months-by people who were not there when the decision was taken, and whose daily work does not even involve such decisions.

Forward Looking Regulation

- Encourage open reporting by having *blameless* postmortems
- Eliminate judgements about right v wrong based on hindsight
- Ensure regulators understand how work gets done not how they imagine it should be
- Don't focus on systems v human error. Look at *individuals in systems* and define where discretionary space (ambiguity, uncertainty and moral choice) begins and ends
- Get operational staff to define that space and explore what is appropriate and inappropriate behaviour

Dekker, S. (2017) *Just Culture: Restoring Trust and Accountability in your Organization*. Third Edition. CRC Press: Boca Raton

Questions

Dr Lucy Wainwright

What would stop us naming contextual hazards?

Dr Cathie Traynor

The aviation, oil industries and the NHS, have all developed ‘Just Cultures’ to manage safety and deaths. Acknowledging Article 2, what would stop us adopting such an approach to prison death investigations?