Conference Report

Prisoner death investigations: Improving safety in prisons and societies?

Wednesday 3rd November 2021 Online

Report author: Dr Gillian Buck

Twitter hashtag **#deathinprison**

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).

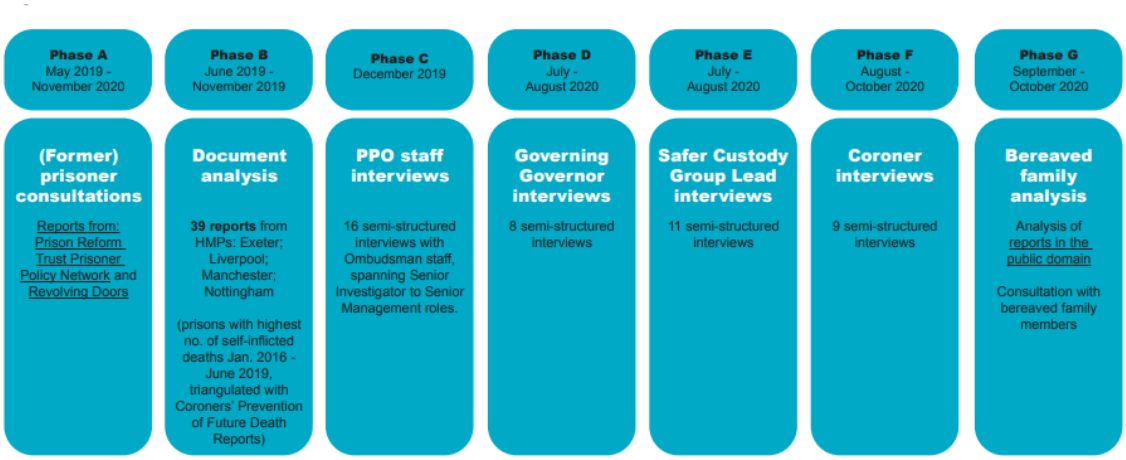
Introduction

The Prisoner death investigations conference was hosted online by the University of Nottingham on the 3rd of November 2021. The conference resulted from work by the Prisons and Probation Ombudsman (PPO) Sue McAllister, Dr Philippa Tomczak and her team at the University of Nottingham. Since 2019, the research team have analysing PPO death investigations in England and Wales, aiming to identify ways to reduce prisoner deaths and improve prison safety, for the benefit of prisons and societies. The focus of the conference was to share findings from the research and consider how the PPO could increase their harm reduction potential.

The event was attended by over 200 representatives from the Prisons and Probation Ombudsman, Inspectors and Coroners, prison staff, health and social care staff, voluntary organisations, government departments, academics and people who have been personally impacted by deaths in prison.

Summary of conference content

Sue McAllister and Dr Philippa Tomczak opened the conference, explaining how their partnership developed and how the research was designed. The image below summarises the stakeholders that participated in the research.

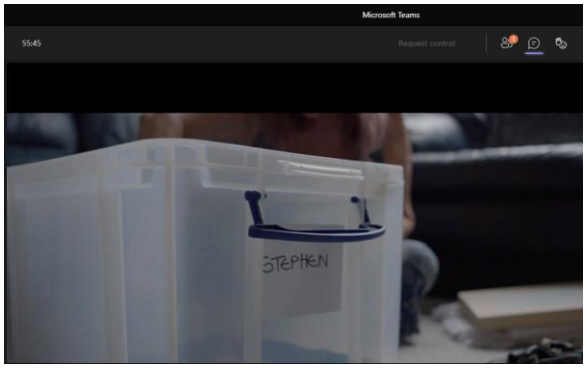


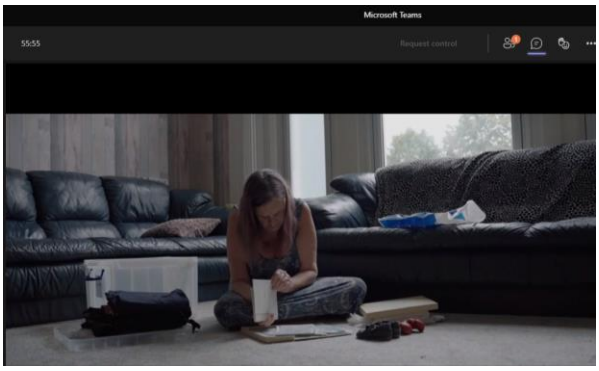
Source: Executive Summary Report.

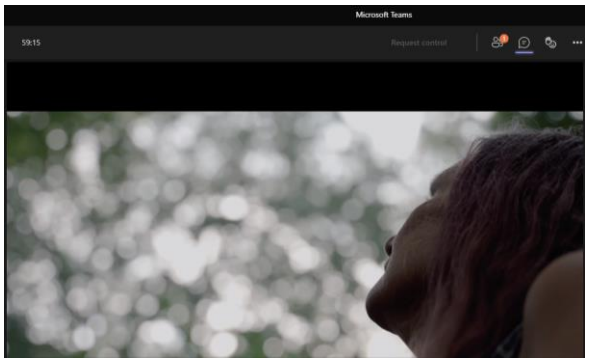
The first paper, from Dr Philippa Tomczak, outlined the (untapped) potential of prison oversight for improving health and safety inside and outside prisons. She advocated collaboration across sectors and scales to amplify shared messages. Two supporting publications are available and free to access:

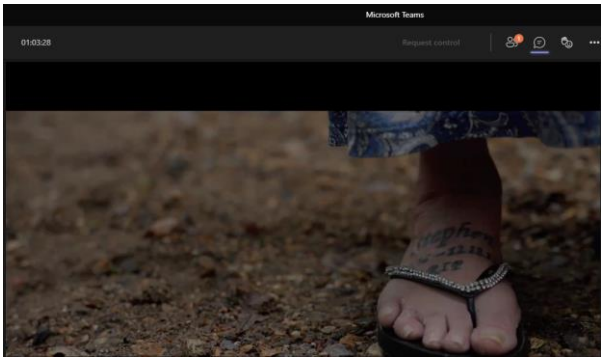
- Tomczak, P. (2021). Reconceptualizing multisectoral prison regulation: Voluntary organisations and bereaved families as regulators. *Theoretical Criminology* OnlineFirst.
- TOMCZAK, P and MCALLISTER, S, 2021. Prisoner death investigations: a means for improving safety in prisons and societies? Journal of Social Welfare and Family Law. 43(2), 212-230

The second presentation was a screening of the moving and important film: “WOODHILL”, produced by Lung Theatre and featuring Janet Farrar, whose son Stephen, died in prison in 2013. Formal death investigations 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. These screenshots depict Janet remembering Stephen and talking about how he walks with her as she tries to move forward.



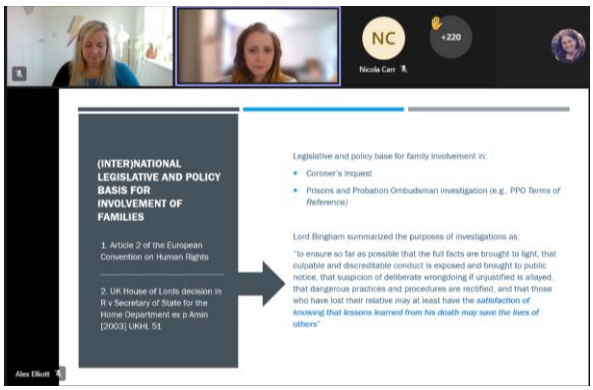


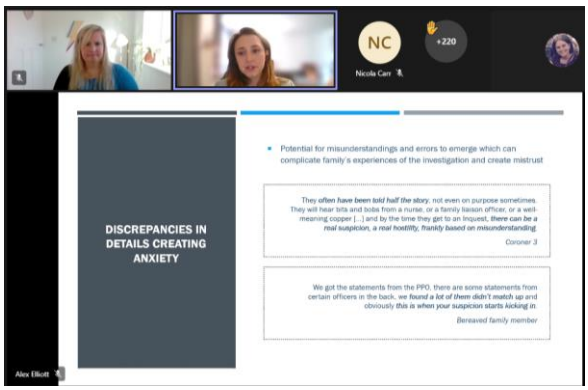




In a question-and-answer session following the film, Janet advocated for more staff in prisons so that mental health needs can be better met; for phones in all cells so that people can reach out to family and friends for support; and for affordable (rather than inflated) ‘canteen’ prices so that prisoners have access to basic supplies whilst living in very difficult environments. Following the event, professionals pledged to give greater consideration to the views and needs of family members in their work.

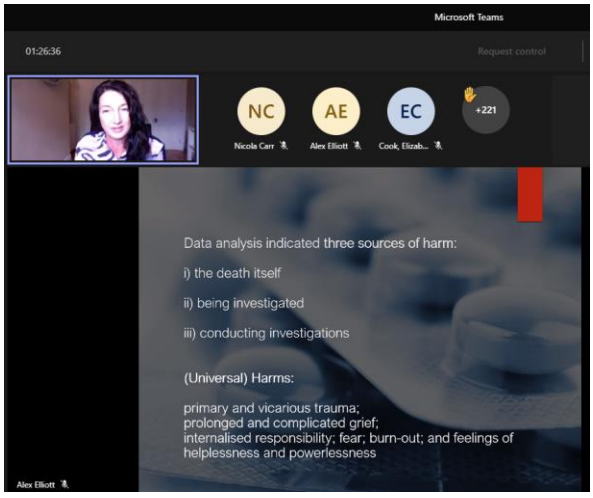
The third presentation, from Dr Elizabeth Cook, considered the harms and benefits of bereaved family ‘involvement’ in prisoner death investigations.

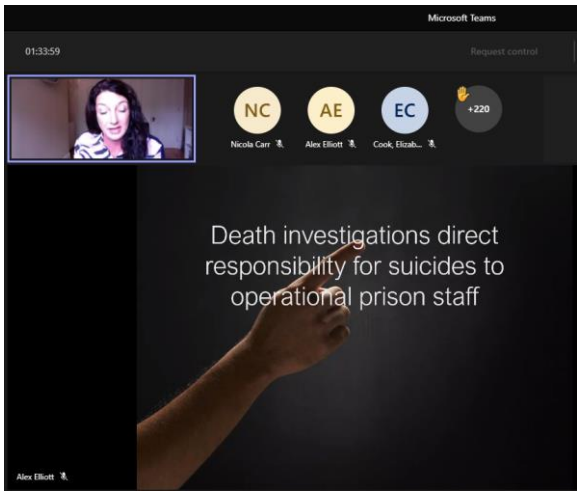




She noted how investigations can prolong families' grief, but catharsis through investigation was frequently assumed. Investigators were urged to consider how families could be better prepared to receive investigation reports, which may be very upsetting, and the support services to which families could be signposted. A supporting publication is available on request from Alex.Elliott1@nottingham.ac.uk: Tomczak, P. & Cook, E. (under review) Bereaved family 'involvement' in (prisoner) death investigations: whose 'satisfaction'?

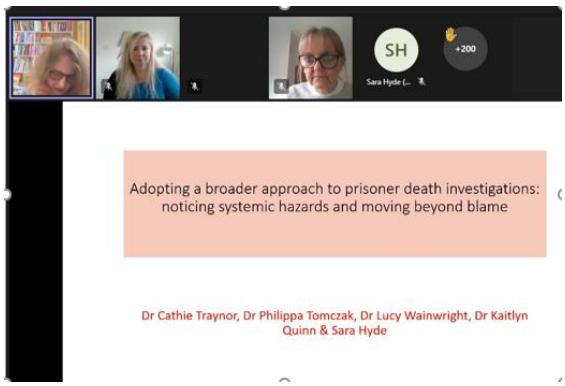
The fourth presentation, from Dr Rebecca Banwell-Moore, explored the unacknowledged harms of prison suicides and investigations across stakeholder groups, including prisoners, bereaved families, prison staff and PPO investigators.

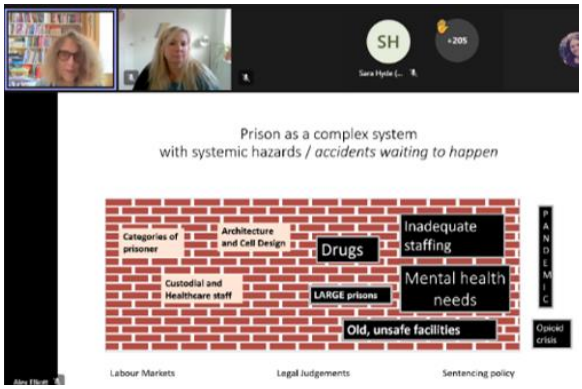




Harms include primary and vicarious trauma; prolonged and complicated grief; internalised responsibility; burn-out; and feelings of helplessness and powerlessness. Rebecca also noted how death investigations direct responsibility for suicides towards staff in individual prisons and how internalising responsibility can have a catastrophic effect on wellbeing. She called on PPO investigators to clarify how they will avoid and mitigate these harms. A supporting publication is available on request from 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.

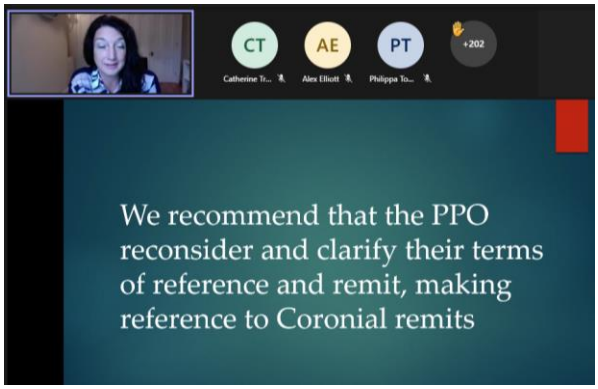
The fifth presentation, from Dr Cathie Traynor, focused on the need for investigators to name systemic hazards and move beyond 'blame'. The PPO is currently set up to undertake narrow, individualised death investigations, producing simple explanations for failures in complex prison systems, yet they do not highlight the 'accidents waiting to happen' across the prison estate. Mental illness; drugs; old, unsafe facilities; large prisons; and inadequate staffing shape the likelihood of deaths nationally. Not naming these hazards means that central decision makers are separated from the trauma of deaths and absolved of responsibility for their policies.





A supporting publication is available on request from 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”.

The sixth presentation, from Dr Rebecca Banwell-Moore, explored Coroners’ perspectives on PPO death investigations.



PPO investigations provide a ‘starting point’ for inquests, helping Coroners to navigate prison files. However, overlapping investigations posed risks of confusion and actions being lost. It was also unclear if PPO witnesses understand that their accounts may be probed in subsequent Coronial and even criminal investigations. As Coroners were keen to nurture cooperation with the PPO, the PPO could support Coroners to make findings that encompass national problems. A supporting publication is available on request from Alex.Elliott1@nottingham.ac.uk: Tomczak, P. (in progress) Coroners’ perspectives on PPO death investigations.

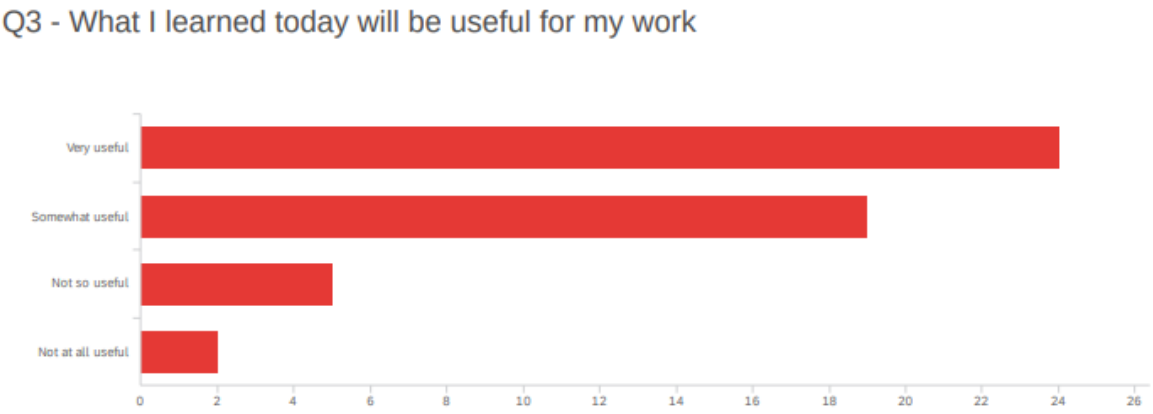
After the papers had been presented, Caroline Mills from the PPO talked about the PPO’s commitment to continuous improvement and how the PPO was trying to enhance the impact of their work by trialling new ways of working and prioritising learning over blame.

Sue McAllister talked about her intention to build upon the recruitment and development of staff members with lived experience of prison.

Following a question-and-answer session, Sue McAllister and Dr Philippa Tomczak thanked the presenters and audience members and invited attendees to complete a short questionnaire aimed at helping the PPO to identify areas to prioritise next.

To read more detailed summary documents, visit:
https://www.safesoc.co.uk/prisoner-death/

Conference feedback



What do you think the Prisons and Probation Ombudsman should prioritise for action next?

- “Bring attention to systemic failures - in particular the lack of staff/ facilities/ activities. Lobby for better training and resources.
- Highlight/ escalate systemic failings of the mental health system within prisons. Highlight the importance of joined up mental health care.
- Ask if prisoners should be in prison and if there are appropriate staff levels.
- The power to look at prevention not just policy compliance.
- Look at systemic issues in deaths. What knowledge/ expertise/ resources are needed?

- Mental Health/ trauma informed education for staff/ Better information sharing especially if long history of mental health issues.
- Further thought to family involvement.
- Build relationships and improve trust to get buy in from HMPPS / Provide informal praise/ increase impact by looking at how and where to make recommendations/ Ensure recommendations are workable in practice.
- Consider impact of death investigations on staff/ Consider problems of single-investigator investigations.
- Review areas for improvement and be open, plan a way forward/ publish progress against recommendations or data proving effectiveness".

Agenda			
Time		**Owner**	**CHAIR**
10.00am	Introduction to the project	Sue McAllister and Caroline Mills Prisons and Probation Ombudsman	Dr Nicola Carr (UoN)
10.05am	The (untapped) potentials of prisoner death investigation	Dr Philippa Tomczak (UoN)	
10.20am	Woodhill: film by LUNG Theatre	Dr Gill Buck (University of Chester)	
10.40am	Bereaved family involvement in prisoner death investigations: whose 'satisfaction'?	Dr Elizabeth Cook (City, University of London)	
10.55am	Prison suicide: unacknowledged harms which ripple across stakeholder groups	Dr Rebecca Banwell-Moore (UoN)	
11.10am	Reflecting on the film: Janet Farrar	Matt Woodhead (LUNG Theatre)	
11.15am	Q+A	Sara Hyde (UoN)	
11.25 BREAK			
11.45	Adopting a broader approach to prisoner death investigations: noticing systemic hazards and moving beyond blame	Dr Cathie Traynor (UoN)	Dr Gill Buck
12.10pm	Coroners' perspectives on PPO death investigations	Dr Rebecca Banwell-Moore (UoN)	
12.25	Response from the Prisons and Probation Ombudsman	Caroline Mills (PPO)	
12.35	Q+A	Sara Hyde (UoN)	
12.55	Conclusion and next steps	Dr Philippa Tomczak (UoN), Sue McAllister	