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Improving prisoner death investigations and promoting change in prisons: A findings and recommendations report

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Executive summary

The Prisons and Probation Ombudsman (PPO) has the responsibility of investigating deaths in custody, alongside Coroners, as required by international law. The PPO's vision is that its investigations will stimulate changes to make 'custody and community supervision safer and fairer'[1]. PPO reports could be a valuable catalyst for changes that improve prison safety, but the sustained high numbers of self-inflicted prisoner deaths in England and Wales suggest that this vision is not currently being realised.

This report draws on the research and findings of Dr Philippa Tomczak and her collaborators at the University of Nottingham since 2019, to offer recommendations to the PPO and policy makers for improving prisoner death investigations and promoting change.

The criminal justice system and its oversight mechanisms involve complicated, multiagency arrangements, hence *all stakeholders* must actively engage with the processes of change required to improve prison safety. We credit the PPO for openly engaging with this research and facilitating broader action.

Key recommendations include:

- The PPO requires **new Terms of Reference** that **transparently, accurately and accessibly** define the PPO's remit and activities. This will have widespread benefits but will be particularly useful for coroners, bereaved families, and prison staff.
- The PPO should **publish the methodology** it uses to investigate prisoner deaths, transparently setting out the evidence base for its judgments and recommendations. It should work with partner organisations to ensure that evidence-based, implementable recommendations are developed.
- To help prevent further deaths, reports into self-inflicted prisoner deaths should not only examine and make recommendations on policy and procedural compliance by staff within individual prisons, but also highlight **'systemic hazards'** – e.g. the warehousing of severely mentally ill people in prisons which are frequently old and unsafe – which are key contributors to self-inflicted deaths.

Investigations into self-inflicted deaths in custody are often traumatic for all involved. Transparency is imperative to reduce the likelihood of the same things happening again. New Terms of Reference, explicit methodology and acknowledgment of systemic hazards would be a significant contribution.

More widely, the report suggests that the PPO should be, and empowered to be, bolder. Its relationship with the National Preventative Mechanism should be clarified to formally recognise the important role its investigations and reports should have in preventing ill-treatment in the future.

[1] https://www.ppo.gov.uk/about/vision-and-values/

This report is authored by Dr Sharon Shalev, independent researcher at SolitaryConfinement.org, with input from Dr Philippa Tomczak at the University of Nottingham.

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Improving prisoner death investigations and promoting change in prisons: a findings and recommendations report

1.The purpose of this report

This report offers recommendations to the Prisons and Probation Ombudsman (PPO) and policy makers and linked bodies for improving investigations into prisoner self-inflicted deaths. The guiding principle behind these recommendations is the need and obligation to reduce the number of self-inflicted deaths in prisons and to reduce the pain and harm they cause, in particular to the loved ones of those who die but also other prisoners, prison staff and indeed PPO death investigators (Banwell-Moore et al, 2022).

The findings and recommendations in this report have been prepared by Dr Sharon Shalev and Dr Philippa Tomczak. They draw on the work and research findings of Dr Philippa Tomczak and her collaborators (at the University of Nottingham: Dr Rebecca Banwell-Moore, Sara Hyde, Dr Kaitlyn Quinn, Dr Cathie Traynor, Dr Lucy Wainwright; at City, University of London: Dr Elizabeth Cook) since 2019, which have been published elsewhere and focus on how prison oversight bodies could better prevent deaths. However, any errors or omissions in this report rest with Dr Shalev and Dr Tomczak alone. Work has involved, alongside extensive documentary analysis of PPO fatal incident reports, a total of 45 interviews with: PPO staff; prison governors; regional Prison Service Group Safer Custody Leads; Coroners; and bereaved families.

The resulting key publications, referred to throughout this report are:

Tomczak, P. (2021). Reconceptualizing multisectoral prison regulation: Voluntary organizations and bereaved families as regulators. *Theoretical Criminology* 26(3) 494–514.

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.

Tomczak, P. and Cook, E. A. (2022). Bereaved family 'involvement' in (prisoner) death investigations: whose 'satisfaction'? *Social and Legal Studies* OnlineFirst.

Banwell-Moore, R., Tomczak, P., et al. (2022). 'The human toll': Highlighting the unacknowledged harms of prison suicide which radiate across stakeholder groups. *Incarceration 3*(2).

Tomczak, P. (2022). Highlighting "Risky Remands" Through Prisoner Death Investigations: People With Very Severe Mental Illness Transitioning From Police and Court Custody Into Prison on Remand. *Frontiers in Psychiatry*, 423.

Tomczak, P., Quinn, K., et al. (forthcoming). (Re)constructing individualised prisoner death investigations: a case study from England and Wales

Tomczak, P. and McAllister, S. (2022). Prisoner Death Investigations: Setting the Agenda for Change. *Prison Service Journal*.

Traynor, C. and Tomczak, P., (forthcoming). The inevitability of blame in adverse event investigations: Towards an assemblage approach to safety.

The report is structured by key themes emerging from the research, as follows:

- Addressing systemic issues
- Promoting change
- PPO ways of working and managing wider harms
- Death investigations: the experiences of families
- The remit of the PPO and multi-agency co-ordination.

2. Self-inflicted deaths in custody: introduction and context

2.1 Introduction

People take their own lives for many reasons. Self-inflicted deaths will happen. They will happen in prison too, where a particularly vulnerable group of people with diverse and complex needs are placed in conditions of great stress.

But, the increased incidence of suicide amongst prisoners in England and Wales compared to the population at large is stark. In the years from 2018 to 2021 there were: 1.1; 1.0; 0.8; and 1.1 self-inflicted deaths per 1,000 prisoners respectively.[2] In the population at large, the equivalent figures for 2018 to 2020 (2021 figures not yet available) are: 0.105, 0.11; and 0.10[3], making suicides in prison between 8 and 10 times higher. Of the 371 deaths in prison custody in the year to 31 December 2021, 86 were self-inflicted, compared to 67 in the previous 12 months.[4]

People in prison are owed a duty of care. The role of the PPO and other investigative bodies is crucial in establishing opportunities to prevent deaths and examining whether and to what extent the state (and/or private companies) have failed to protect, or even contributed to endangering, the lives of those who have died by suicide.

Equally, part of the state's duty of care is to learn lessons and put in place mechanisms that minimise the likelihood of and its culpability for deaths of people in its care. That requires robust investigations, reports, recommendations and mechanisms to follow up implementation.

2.2 Investigating deaths in custody: international regulation

The state has an obligation to investigate deaths in custody. All deaths in prison that are related to self-harm automatically engage Article 2 of the European Convention on Human Rights ('Article 2'). The European Court of Human Rights ('ECtHR') has found that Article 2 imposes a positive obligation on the state to take preventative operational measures to protect any individual in their care whose life is at risk from self-harm where the authorities knew or ought to have known there was a real and immediate risk to life of the identified individual.[5]

[2] See Deaths in Prison Custody 1978 to 2021 table within Safety in custody: quarterly update to December 2021 - GOV.UK (www.gov.uk) dataset
[3] See Suicides in England and Wales - Office for National Statistics (ons.gov.uk)
[4] See Deaths in Prison Custody 1978 to 2021 table within Safety in custody: quarterly update to December 2021 - GOV.UK (www.gov.uk) dataset
[5] See Keenan v United Kingdom, no. 27229, 3 April 2001 ECHR (hr-dp.org)

Article 2 includes a procedural element which requires the investigation of deaths in custody. Whilst European Court of Human Rights judgements allow some flexibility as to the form of the investigation, they set out requirements for independence, adequacy, promptness, public scrutiny, and the involvement of next of kin.

The Minnesota Protocol[6] on the Investigation of Potential Unlawful Death (the 'Minnesota Protocol'), provides another benchmark. Its provisions apply in all cases where the death occurred when a person was detained by, or was in the custody of, the State, its organs, or its agents. '*This includes, for example, all deaths of persons detained in prisons, in other places of detention (official and otherwise) and in other facilities where the State exercises heightened control over their life.'* Some of the elements and principles of investigations set out in the Minnesota Protocol bear repeating here:

> *International law requires that investigations be: (i) prompt; (ii) effective and thorough; (iii) independent and impartial; and (iv) transparent* (paragraph 22)
>
> *An investigation must be carried out diligently and in accordance with good practice. The investigative mechanism charged with conducting the investigation must be adequately empowered to do so. The mechanism must, at a minimum, have the legal power to compel witnesses and require the production of evidence, and must have sufficient financial and human resources* (paragraph 27)
>
> *States should, at a minimum, be transparent about the existence of an investigation, the procedures to be followed in an investigation, and an investigation's findings, including their factual and legal basis* (par. 32)
>
> *The duty to investigate does not necessarily call for one particular investigative mechanism in preference to another. States may use a wide range of mechanisms consistent with domestic law and practice, provided those mechanisms meet the international law requirements of the duty to investigate… Whichever mechanisms are used … they must, as a whole, meet the minimum requirements set out in these Guidelines* (par. 38)

[6] The Minnesota Protocol on the Investigation of Potential Unlawful Death – the United Nations Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions MinnesotaProtocol.pdf (ohchr.org)

2.3 Previous government and voluntary sector reviews of death investigations in the United Kingdom

There have been several reviews of death investigations in the UK in recent years. These provide important context and learning, and some are briefly introduced below.

The **2015 Harris Review**, *Changing Prisons, Changing Lives*[7] noted that there should be a duty of candour on prison service staff towards the PPO and coroner and families and friends of the deceased young adult. It recommended that arrangements for follow up actions on PPO reports and inquest findings be enhanced. It emphasised that Her Majesty's Inspectorate of Prisons (HMIP) should review progress achieved on implementing previous PPO recommendations (using any reviews that the PPO may have conducted), and any previous coroners' jury findings and Prevention of Future Deaths reports. It expressed concern about the quality of clinical reviews undertaken for PPO investigations. It also expressed concern about the impact on families, prison staff and organisational learning of long delays to inquests and advocated close working between the Chief Coroner and PPO in order to reduce those. The Review suggested that Parliament should have a much greater role in oversight of the inspection process, which should be made fully independent of the Ministry of Justice, and in driving the changes that are needed.

The **Care Quality Commission's (CQC) 2016 review** of the way NHS trusts review and investigate the deaths of patients (particularly those with a mental health problem or learning disability) in England, *'Learning, candour and accountability'*[8] found that families and carers were often not listened to; not consistently treated with respect, honestly or sensitivity; and not reliably kept informed. It found inconsistencies in the quality of and approach to investigations, despite the existence of the serious incident framework, significant issues with timeliness, and confusion about the roles of different agencies. Systems for disseminating learning and following up recommendations were weak. The CQC's recommendations included: ensuring that relatives and carers were meaningfully involved; focussing reviews on system analysis rather than individual errors; and better dissemination of learning. A follow-up to the review in 2019 suggested a mixed picture on implementation.[9]

INQUEST's 2012 report '*Learning from Death in Custody Inquests: A New Framework for Action and Accountability*'[10] noted that the lack of mechanisms to follow up on action taken by detaining agencies in the light of coroners' findings meant that learning from

[7] The Harris Review - Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds - June 2015 (publishing.service.gov.uk)
[8] Learning, candour and accountability | CQC Public Website
[9] Learning from deaths | CQC Public Website
[10] Learning from Death in Custody Inquests: A New Framework for Action and Accountability | Inquest

coronial inquests was lost. It recommended the creation of a new central oversight body to address those shortcomings, and a more co-ordinated response by investigation and inspection bodies after inquests.

Stephen Shaw's 2017 *Independent Professional Advice on the Prevention of Self-Inflicted Deaths and Self-Harm at HMP Woodhill*, following the very high number of self-inflicted deaths there – 20 between 2011 and 2016 – found that there was now a strong focus on prisoner safety. But, in the context of a high proportion of prisoners at risk of self-harm and a culture of risk aversion, staff shortages and high staff churn resulted in continuing inadequacies in the recording of data and acute pressures on the prison.

Stephen Shaw's 2018 report[11], assessing implementation of his 2016 report on vulnerable people held in immigration detention, made a number of recommendations which are of relevance here, including: mandatory annual safer detention training for staff; more research into deaths in immigration detention, 'near misses' and incidents of serious self-harm; and the Home Office devising and publishing a strategy for reducing the number of deaths from natural causes and those that are self-inflicted in, and shortly after, immigration detention.

Finally, in **Scotland, the *2021 Independent Review*** *into the Response to Deaths in Prison Custody* highlighted shortcomings of the current Fatal Accident Inquiry process. Its principal recommendation was that an independent investigation should be undertaken into each death in prison custody, carried out by a body wholly independent of the Scottish Ministers. The review also made key recommendations around next of kin involvement; setting investigations in a human rights framework and having regard to applicable human rights standards throughout; and the publication of reports analysing deaths in custody.

Many of the recommendations of the reviews cited above are repeated or echoed in this report and would benefit PPO investigations. As Stephen Shaw noted[12] '*I have found a gap between the laudable intentions of policymakers and actual practice on the ground*.' There is a need for repetition as well as new insights if the necessary changes are to happen.

[11] Cm 9661 – Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons – July 2018 (publishing.service.gov.uk)
[12] Op. cit. page ix.

Findings and recommendations

3. Systemic issues affecting deaths in custody and the need to address these

3.1 Systemic hazards and misguided perceptions of prison as a place of safety

Self-inflicted prisoner deaths need to be set in a context of over-incarceration in England and Wales; record numbers of prisoners on remand[13]; increasing sentence lengths; an over-stretched and severely understaffed prison system, often equipped with old facilities; and a chronic lack of health services. The team's research identified widespread concern amongst prison staff about persistent, problematic conceptualizations of prison as a 'place of safety' for people with severe mental illness; severe difficulties in facilitating transfers to secure hospitals; and inadequate mental health services to meet the level of need amongst prisoners.

It is our view that reducing deaths in prisons in a significant and sustained way will not be achieved unless 'systemic hazards' are also addressed (Tomczak, 2022; Tomczak et al. 2022). Focussing NHS reviews of patient deaths on system analysis rather than individual errors was also a core recommendation in the CQC's 2016 review. Achieving all these changes is not in the gift of the PPO, but we consider it important that PPO investigations and recommendations acknowledge the role that 'systemic hazards' may have played in prisoner deaths. Coroners were clear that they cannot adopt this systemic lens, hence the PPO must.

Much about the contemporary prison system in England and Wales is likely to increase the risk of self-inflicted deaths in custody, including the availability of drugs; old, unsafe facilities; and inadequate staffing. A very significant systemic hazard is the large number of seriously mentally unwell people warehoused in prisons when a least-restrictive therapeutic environment would be more appropriate. And that hazard is likely to be at its most acute for those who have recently arrived there on remand.

Prison is too frequently accepted as a 'place of safety' or pathway into secure healthcare for those with severe mental illness. In England and Wales, the National Health Service and criminal justice system now have a joint responsibility for diverting people from prison if they and wider society are better served by addressing underlying health problems. Yet,

[13] https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-april-to-june-2022/offender-management-statistics-quarterly-april-to-june-2022

diversion appears to work better for people suspected of less serious crimes[14] and is dependent on the availability of local mental health services.

More widely, there is growing recognition that custodial settings should not be viewed as a 'place of safety' for the severely mentally ill.[15] The National Police Chiefs' Council's 2020 National Strategy on Policing and Mental Health notes that: "*The police service should work to completely eliminate reliance upon the use of police custody as a Place of Safety under the Mental Health Act 1983 - this has already been achieved in some police force areas like West Midlands and Merseyside. It is also a recommendation in the Mental Health Act Review*".

The PPO, and indeed all prison oversight bodies must acknowledge systemic issues in their investigations, not least to inform coroners and bereaved families. Some of the local good practice, such as the joint work between the police and mental health services in the West Midlands and Merseyside, should be adopted more widely and promoted by prison oversight bodies. We further discuss multi-agency work later in this report.

3.2 The lack of reference to systemic hazards in PPO reports

PPO investigations are narrowly focused on individual deaths. The PPO produce good quality reports, but the team's interviews with PPO staff reinforced that their emphasis is, **implicitly**, on **establishing whether the Prison Service's own policies were followed**. They do not make this methodology explicit in investigations or adequately highlight the wider factors - 'the systemic hazards' - that make those deaths more likely, including: insufficient mental health provision; the availability of drugs; old, unsafe facilities; and inadequate staffing, according to prison staff (Tomczak et al. 2022).

This narrow approach to cause and effect risks over-apportioning blame to individual prison officers or suggesting that deaths were not preventable when they were a result of system wide failings. It means that recommendations directed to individual prisons may not identify the changes required to make the most difference. Simple fixes are unlikely to work in individual prisons when they relate to structural problems across the prison estate and **risk displacing problems** between prisons.

Multiple stakeholders that the team interviewed were clear that successful death prevention lay principally in tackling 'upstream' problems that lay outside individual prisons' control. Operational staff mentioned important contributors to self-inflicted deaths

[14] See *Reveruzzi and Pilling*, 2016

[15] We note for example that Stephen Shaw in his 2016 review into the welfare in detention of vulnerable persons recommended that no-one suffering from serious mental illness should be held in immigration detention.

in custody including: holding very mentally unwell people in prison; inadequate mental health provision in prison; staff cuts and shortages; old and unsafe facilities; and the prevalence of drugs.

Focussing on the issue of inadequate mental health pathways, we examine the deaths of four individuals with severe, acute mental illness (Lewis Francis, Jason Basalat, Dean Saunders and Sarah Reed) who took their own lives in prison between January 2016 and April 2017 (Tomczak, 2022). These are all troubling and raise system-wide issues. Lewis Francis was declared unfit to be interviewed in police custody, but then spent over two months in prison before his death. Jason Basalat was unable, on coming to court from police custody, to have a mental health assessment because it was a Saturday morning. He died in prison less than 24 hours later. Sarah Reed died after being detained in prison for nearly two months solely for the purpose of obtaining reports on her fitness to plead and stand trial. Dean Saunders died two weeks after being remanded in prison because no space was available for him in a forensic mental health ward.

The PPO investigations into all of these deaths did not highlight the dangers of remanding people with severe, acute mental illness to prison, although all of the coroners subsequently did so. That failure to engage with the remand to prisons of severely mentally ill people – 'risky remands' – represents a missed opportunity to better explain self-inflicted deaths and highlight and challenge a key systemic hazard (Tomczak, 2022).

It is our view the PPO investigations and reports must consider the roles that inadequate transition pathways for the seriously mentally ill, and other systemic hazards, have played in self-inflicted deaths in custody (Tomczak et al. 2022). The PPO's Terms of Reference are clear (paragraph 32): establishing the circumstances and events surrounding the death should include taking account of 'any relevant external factors'. These should be reflected in PPO reports, or the Terms of Reference should be revised to reflect the PPO's practice.

Taking proper account of 'systemic hazards' in investigations will serve to enhance understanding, more fairly apportion responsibility between prison staff and decision makers at a national level and help inform recommendations.

3.3 Recommendations on addressing systemic issues

- **PPO reports should reflect the role that 'systemic hazards' have played in the death in prison**.
- Death investigators should consider what individual prison governors and staff can control and who, beyond the prison, holds responsibility for systemic hazards.
- **PPO investigations into suicides of those with severe mental illness should highlight the dangers of holding these individuals in prison**. It is hard to see how the PPO's vision that their investigations should make 'custody and community supervision safer' can be properly fulfilled if they do not do so.

Wider recommendations:

- Prisons should not be used as a place of transition from the courts and police custody into secure healthcare facilities. The PPO and other prison oversight bodies should consider their responsibility in advocating a clear remand pathway from the courts and police custody into least restrictive therapeutic environments for those with severe mental illness who are charged with crimes.
- Mental health assessments should be available at all times for those in police and court custody to determine the appropriateness of a transfer to prison.
- Remand to prison should not be used for the severely mentally ill as a means of obtaining reports on fitness to plead. Greater clarity is needed on whose responsibility it is to obtain these reports.
- Magistrates and Crown Court judges should be educated on the risks of remanding people with severe mental illness to prison and the level of care for this group that can reasonably be expected there. That should include visiting local prisons to better understand why prisons are inappropriate for people with severe mental illness.

4. Promoting change

4.1. Does the PPO have a role in promoting change?

Establishing the facts must be central to any investigation of a self-inflicted death. But learning for the future is critical too. The PPO's terms of reference note that the aims of their investigations include that 'any lessons from the death are made clear'. It is our view that currently too little is being done to create effective feedback loops where lessons can be learned from individual death investigations and then used to inform and support wider change on the ground. As Sapers and Zinger (2009) note:[16] "Any office that [. . .] investigates complaints is only doing half its job if its casework experience is not used to provide comprehensive feedback. [. . .] Such feedback could [. . .] lead to improvements when investigations reveal systemic problems or failures."

We would like to see a more self-confident PPO, emboldened through revised Terms of Reference and with a clearer relationship to the National Preventative Mechanism. The PPO should give real voice to their reconsidered recommendations to reduce self-inflicted deaths, including in relation to systemic hazards, and continue to press for their implementation.

4.2 Does the PPO effect wider change?

Too little has been done to reflect on PPO recommendations and translate recommendations from PPO investigations into prison suicides into action on the ground. The same recommendations have been repeated over a number of years but with an insufficient focus on the utility of those recommendations, how those responsible for implementation might best be engaged or the evidence base to underpin action.
The team's interviews with PPO staff found that they were deeply frustrated by making the same recommendations year after year. Whilst prisons are required to produce an action plan in response to recommendations, there is no effective mechanism to assess whether that has been implemented. PPO staff referenced repeat recommendations as evidence that investigations were not having the impact on learning that they should, but tended to place the blame on prisons (Tomczak and McAllister, 2021).

A similar accountability deficit is evident in coroners' Prevention of Future Death reports. No one is responsible for judging whether responses to these are appropriate and effective and there is no consistent mechanism for assessing implementation.

[16] Formerly the Canadian Correctional Investigator and Executive Director of the Office of the Correctional Investigator, respectively. Sapers, H. and Zinger, I., 2009. The ombudsman as a monitor of human rights in Canadian federal corrections. *Pace L. Rev.*, *30*, p.1512.

A database of previous recommendations is held by the PPO and provides a valuable source of learning to draw on but appears to be little developed. It is striking that the thematic report categorising fatal incident recommendations *'Learning from PPO Investigations'* to which the PPO website directs readers dates from 2013.

The 'learning lessons' reports published by the PPO are a valuable means by which common themes from investigations into self-inflicted deaths can be identified and recommendations given real force by the weight of evidence behind them. They provide an opportunity to amplify key messages.

4.3 Recommendations on effecting wider change

- Work should be undertaken to **build, clarify and substantiate the evidence base for the PPO's recommendations**.
- The PPO should consider its role in stimulating policy debates around wider issues including, for example, alternatives to holding severely mentally ill people in prison; the use of remand; mental health services in the community and in prisons.
- The **PPO should regularly publish thematic reports on self-inflicted deaths** drawing on its recent investigations. Consideration should be given to making this a joint report with other agencies involved in deaths in custody work.
- The PPO should promote good practice locally, and periodically publish reports to highlight good practice they have encountered in the course of their investigations and promote this, in particular with the Prison Service.

Wider recommendations:

- **Further work should be undertaken to assess the extent to which, in relation to self-inflicted deaths, recommendations in PPO and Coroner's Prevention of Future Death reports have actually been implemented** as opposed to simply accepted. Where recommendations have not been implemented this should be followed up.
- Multi-agency consideration should be given to how to create **more robust mechanisms to secure the implementation of evidence-based recommendations,** for example through Her Majesty's Inspectorate of Prisons inspections.
- More research should be undertaken to understand the impact of investigations into self-inflicted deaths and prison oversight more generally in improving outcomes in prisons.

5. PPO ways of working and managing wider harms

5.1 PPO ways of working

The principles for the investigation of prisoner deaths set out in human rights instruments – that they are prompt; effective and thorough; independent and impartial; and transparent – are clear, but they do not illuminate the often complex and traumatic process that is involved for all stakeholders.

Investigations need to follow a clear, consistent, and well understood process, underpinned by a robust, transparent methodology. Unlike, for example, Her Majesty's Inspectorate of Prisons which sets out the criteria it uses to inspect prisons in its 'Expectations' documents[17], the PPO provides publicly only a cursory explanation of how it investigates fatal incidents. **No detailed methodology is readily available**, and recommendations are not sufficiently underpinned by an **evidence base** on the type of changes that are most likely to contribute to a reduction in self-inflicted deaths in prisons (Tomczak and McAllister, 2021).

As well as a need for transparency around methodology, there needs to be further recognition of the very difficult context in which death investigations are undertaken for all concerned, including prison staff.

Yet, the team's interviews with PPO staff found some lacking confidence in managing (sometimes difficult) interpersonal relationships with prison staff; some feeling unsupported; and a lack of consistency and standardisation of investigations and how they're conducted. For example, there was inconsistency about how and when feedback to prison staff/ governors happens (Tomczak and McAllister, 2021).

A clearer set of methods and expectations may go some way to clarifying these issues and assist PPO staff in managing their work.

5.2 Managing wider harms

PPO investigations into prison suicides tend to direct blame towards prison managers and staff. That, in turn, unhelpfully creates an atmosphere of defensiveness, indignation and fear. The open and collaborative approach that is most likely to yield the best investigations and recommendations, which are subsequently implemented, becomes compromised. Prison staff feel personally blamed for not being able to prevent deaths, which has implications for staff wellbeing and prison safety. There is frustration amongst prison staff that the PPO does not appear to recognise how hard it can be to prevent a

[17] See Our Expectations (justiceinspectorates.gov.uk)

suicide amidst the difficult conditions in the estate. There is also frustration that good practice is not acknowledged or shared (Traynor and Tomczak, forthcoming).

Blame may be hard to avoid in some investigations into self-inflicted prisoner deaths, but distrust and fear of investigations are the inevitable consequences. It is essential that investigations **do not start from the implicit assumption that individual failings of policy compliance within prisons are always and inevitably where responsibility for the death lies**. We discuss in more detail below the role of the PPO in addressing system-wide problems and failures, noting that responsibility for self-inflicted deaths may lie beyond the prison gates. Formally praising staff in the context of self-inflicted death investigations is clearly difficult and potentially upsetting for families, but we should acknowledge the wider positive impacts that documenting good practice and sharing praise may bring, alongside the negative ones attached to blame.

The team's research suggests that communications by PPO investigators to prison staff in the course of investigations are overwhelmingly about deficits. PPO staff expressed concern that prison officers are blasé about PPO investigations (Traynor and Tomczak, forthcoming).

Little attention appears to have been given to adopting the adapted 'just' approaches to investigations that are widespread in, for example, the health sector. In sum, all parties want to see fewer suicides, but the research suggested that this shared aim is not yet mobilised by death investigations. Rather, the death investigation compounds the harms of death and creates additional harms of burden and fear, and staff feelings of being undervalued and unacknowledged. Moreover, prison suicide may result in frustration and professional burn-out, further compromising safety. Prison and PPO staff frequently adopt coping mechanisms that negatively impact prison-staff relationships and prison safety (Banwell-Moore et al, 2022).

5.3 Recommendations on PPO ways of working and managing wider harms

Ways of working

- The PPO should **establish and publish the methodology it uses to investigate self-inflicted deaths**. This should transparently set out how evidence is collected, analysed and assessed.
- The PPO should set out the evidence base for their conclusions and recommendations more clearly, explaining the basis on which they judge a death to be, or not be, predictable or preventable, taking account of systemic hazards.
- The PPO should pilot a revised fatal incident report structure and revised recommendations drawing on findings in this report and lesson learning strategies. Consideration should be given to whether the urgency and/or priority of recommendations should be indicated.
- Further training should be provided to PPO staff to ensure greater consistency in the conduct of investigations and how they interpret their role as investigators. Training should include a mental health component, as well as trauma informed interviewing techniques.

Managing wider harms

- The PPO and the Prison Service should refocus on how prisoner suicide and death investigations affect their staff and adapt their practices accordingly.
- The PPO **should set out how it seeks to mitigate and minimise the harm that its investigations may cause to both prison staff and its own staff**.
- Consideration should be given to how further support can be signposted and made available to PPO staff and prison officers affected by suicides to help them better manage primary and secondary trauma.
- Consideration should be given to whether PPO staff might change roles more regularly and/ or rotate with seconded staff from other departments to reduce the cumulative burden – the 'overload of death' - from investigating self-inflicted deaths over many years.
- The PPO should provide informal positive feedback to prison staff where they deserve credit and consider how to document and disseminate examples of good practice.

- PPO reports and recommendations should reflect the role that 'systemic hazards' may have played in the self-inflicted death.
- Further consideration should be given to an initial stage of 'off the record' interviews with prison and healthcare staff to establish context and help individuals understand the changes within and beyond their control, prior to the established investigatory approach. The report would reflect both parts of the process.

6. Death investigations: the experiences of families

6.1 The role of families in death investigations

One aim of the PPO's investigations is to 'provide explanation and insight for the bereaved relatives'. The House of Lords, in *R v Secretary of State for the Home Department ex p Amin (2003) UKHL 51*, identified that an investigation under Article 2 of the European Convention on Human Rights should, among other things, ensure 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.'

The Minnesota Protocol sets out in detail the role and protection family members should be granted during an investigation:

> *The participation of the family members or other close relatives of a deceased or disappeared person is an important element of an effective investigation. The State must enable all close relatives to participate effectively in the investigation, though without compromising its integrity. The relatives of a deceased person must be sought and informed of the investigation. Family members should be granted legal standing, and the investigative mechanisms or authorities should keep them informed of the progress of the investigation, during all its phases, in a timely manner. Family members must be enabled by the investigating authorities to make suggestions and arguments as to what investigative steps are necessary, provide evidence, and assert their interests and rights throughout the process. They should be informed of, and have access to, any hearing relevant to the investigation, and they should be provided with information relevant to the investigation in advance. Where necessary to ensure that the family members are able to participate effectively, the authorities should provide funding for a lawyer to represent them. In the case of a child (and where there are no other relatives), a trusted adult or guardian (who may not be related to the deceased or disappeared person) may represent the interests of the child. In certain circumstances – for example, where family members are suspected perpetrators – these rights may be subject to restrictions, but only where, and to the extent, strictly necessary to ensure the integrity of the investigation.* (paragraph 35).
>
> *Family members should be protected from any ill-treatment, intimidation or sanction as a result of their participation in an investigation or their search for information concerning a deceased or disappeared person. Appropriate measures should be taken to ensure their safety, physical and psychological well-being, and privacy*. (paragraph 36).

As such, family involvement in investigations may bear substantial harms as well as benefits. Investigations can inadvertently amplify and prolong grief.

The processes of death investigations in England and Wales illustrate this problem. Families receive multiple reports over extended time periods, for example the PPO report, clinical review, pathology findings, coroners' Prevention of Future Death report and organisational responses. Discrepancies and misunderstandings are very likely to occur in multi-stakeholder investigations into traumatic events that extend over months and frequently years, making effective understanding of the process, mitigations and support imperative.

Statutory provision for bereaved prisoners' families comprises only the prison and PPO Family Liaison Officers. Any further support is provided ad hoc by voluntary organizations, primarily INQUEST, including gaining legal representation and often funding for it. Legal representation and support have enabled bereaved families to make important contributions to changes across the prison estate through litigation or the threat thereof. Litigation threatened by families triggered, for example, the *Corston Report* on women with vulnerabilities in the criminal justice system, and the 2015 *Harris Review* on self-inflicted deaths in custody of 18 to 24-year-olds. A judicial review brought in 2016 by two bereaved families, with INQUEST intervening, against the Justice Secretary and the Governor of Woodhill Prison over failures to comply with the duty to protect prisoners from suicide, was followed in 2017 by Woodhill's first suicide free year for seven years (Tomczak, 2021).

6.2 How families experienced death investigations

Interviews revealed that families appreciated being given 'the facts' of what happened, and PPO staff and coroners thought it was important to communicate these to the families. PPO staff were, however, given no training on how to do so, even though communicating about a relative's death is a highly sensitive task which risks re-traumatising families and exacerbating grief. Particular issues arose for families when investigation details were inaccurate, patchy, or delivered insensitively, with some feeling that details had been omitted or deliberately re-narrated (Tomczak and Cook, 2022). The potential harms and costs of investigations were rarely acknowledged by PPO staff or coroners, and mitigations such as referral to support and information services for families were unexplored.

Although bereaved family 'satisfaction' was regularly spoken about by investigators and invoked to legitimise investigations, the research found a striking absence of evidence illustrating the 'satisfaction' of bereaved families. The PPO Bereaved Families Survey gathers very limited information on overall 'satisfaction' with the investigation, including

communication, information, and the Family Liaison Officer. Views are primarily collected through a Likert survey, revealing little substantive detail regarding 'satisfaction'. Moreover, the survey has a low response rate and is conducted irregularly (Tomczak and Cook, 2022).

The team's research suggested that families hope investigations will 'stop people dying', and that preventive aim is supported by the *Minnesota Protocol* and the Court's judgement in *Amin* (cited above). There is a disparity though between the extent to which some families believe they will be able to shape the investigation and their ability to do so within the current remit of the PPO.

6.3 Recommendations regarding family involvement in death investigations

- A short, clear explanation of the investigation process and what the PPO, and other agencies involved in investigating suicides in prisons, do **(and do not do)** should be provided to families of the bereaved at the outset of the investigation, to help manage expectations. This should be provided both verbally and **in printed form**.
- The needs and wishes of relatives could also shape the remit of the PPO, from acknowledging systemic hazards to enabling families to comment on personal facts to do with the deceased, for example.
- The PPO should ensure that families are prepared for the receipt of draft and final investigation reports, which may be very upsetting.
- Signposting to support services should be provided by the PPO.
- The PPO's bereaved families survey should be reviewed with the aim of improving the response rate and gaining a richer understanding of family 'satisfaction'.
- Specialist training should be provided to PPO staff on communicating with bereaved families.

Wider recommendations:

- Coroners should better prepare and signpost families to receive and understand materials including toxicology and pathology reports.
- Further consideration should be given to whether the same prison Family Liaison Officer should be responsible for assisting the family if they are also supporting prison staff at inquest.

7. The remit of the PPO and multi-agency co-ordination

7.1 The PPO's remit and its interpretation

Unlike the 21 bodies that make up the UK's National Preventative Mechanism, including Her Majesty's Inspectorate of Prisons (HMIP) and the Independent Monitoring Boards (IMB) who do similar work and also play a role in preventing deaths in custody, the PPO does not have a statutory basis.[18]

Further, there are significant similarities between the role of coroners in relation to deaths in prisons and the role of the PPO: establishing the facts around the death and, where coroners' inquest requires, drafting a 'Prevention of Future Death' report, requiring the responsible organisation to take the prescribed action. Article 2 and the Minnesota Protocol require that where the PPO is empowered to investigate, it must do so promptly, effectively, thoroughly, independently, impartially and transparently, and involve the deceased person's next of kin (Tomczak and Cook 2022). Where investigatory responsibilities rest with other bodies e.g. the coroner, there needs to be clarity and confidence that collectively the requirements of Article 2 and the Minnesota Protocol are met.

The PPO's vision, as articulated on its website, is 'to carry out investigations to make custody and community supervision safer and fairer'. It is hard to see how that vision is being substantively realised whilst self-inflicted deaths in prisons remain high. The question that needs to be asked is whether the PPO is unable to realise its vision because its remit does not extend far enough, or because the PPO interpret its remit too narrowly when carrying out their work.

Looking at the PPO's Terms of Reference (2021 revision), the PPO's remit appears to be widely, if vaguely, articulated. There is much emphasis on the PPO's independence, which is crucial and required by Article 2 as well as the Minnesota Protocol, but it is not entirely clear what authority and weight the PPO carries, and the degree to which its findings and recommendations are useful and need to – or can - be acted on by the relevant authority.

The Terms of Reference also risk creating unrealistic expectations. The stated aim of investigations, for example at paragraph 32: to 'provide explanations and insight for the bereaved families', is a case in point of drafting which both overpromises and is unhelpfully vague, as will be discussed in greater detail later in this report.

[18] Other public bodies with a role in investigating and/or seeking to reduce deaths in custody include the Independent Office for Police Conduct which is responsible for investigating deaths in police custody and the Independent Advisory Panel on Deaths in Custody.

7.2 Multi-agency work around deaths in custody

The processes for investigating deaths in custody are complex and confusing. Overlapping agency remits make them more complex. The are many parallels between the work of the PPO and that of coroner's inquests, and the relationship between the two bodies is not entirely clear. The Prisons and Probation Ombudsman Terms of Reference provide (at paragraph 58) that protocols will be developed in order to describe the Ombudsman's relationship with relevant partners, though we note that the joint memorandum of understanding with the Coroners' Society appears to date from 2012.

Some of the specific concerns the research team identified included:

- Clinical reviewers, commissioned by the NHS/ Healthcare Inspectorate Wales to examine clinical decision making, have parallel but diverging remits to coroners. Coroners need to determine whether inadequate care caused or contributed to the death, but clinical reviewers do not consider that, potentially creating difficulties.

- Clinical review work is sometimes of an inadequate standard. Coroners considered that the clinical reviewers had inappropriate expertise and too frequently could not justify their conclusions and recommendations, which were incorporated into PPO reports. Not only are coroners concerned about the quality of clinical work undertaken, but the fact that this is commissioned by the NHS may create perceptions of a lack of independence.

- Lack of clinical expertise meant that sometimes the clinical reviewer changed their judgement at inquest. This could cause delays as well as having consequences for the trust and confidence of bereaved families.

- PPO reports have a quasi-evidential, quasi-legal function. It is unclear whether witnesses consistently understand that their accounts may be subsequentially probed in coronial and even criminal investigations.

- The potential for PPO recommendations followed by the coroner's Prevention of Future Death Report risks actions being lost in a long list and confusion for the services involved and bereaved families.

The team also identified disparities between the PPO and coroner's findings in the same cases (Tomczak, 2022; Tomczak and McAllister, 2022). That is likely to create further confusion for the services involved and the bereaved families. It highlights the need to question **what particular agencies recommend, based on which evidence** and the narrative that taking effective action is merely a matter of implementing recommendations.

Better multi-agency co-ordination on deaths in custody work is likely to helpfully amplify and make clearer the message on what needs to change, but co-ordination is rendered more difficult by overlapping remits. We would note that the coroners whom we spoke to were keen to nurture earlier engagement and co-operation and saw PPO reports as providing good background information and a helpful digest of key issues.

7.3 Recommendations on the remit of the PPO and multi-agency working.

Status of the PPO

- **The PPO should be put on a statutory footing.** We note this was recommended by the Joint Committee on Human Rights as far back as 2004,[19] in particular to provide additional assurance as to the independence of investigations in and in turn their compliance with Article 2 of the European Convention on Human Rights.
- The PPO's relationship with the **National Preventative Mechanism** (NPM) should be clarified so that past oriented fatal incident investigation reports can better inform death prevention work and prevent ill-treatment in the future – the central role of the NPM as established under OPCAT.

Remit of the PPO

- Clinical reviews commissioned by the NHS/Healthcare Inspectorate Wales should be more clearly distinguished from PPO Fatal Incident Reports. Current reporting arrangements may wrongly suggest that the PPO has some oversight responsibility for clinical reviews when they lack the clinical expertise for that role. Merely summarising a clinical review is likely to be a poor use of resources.
- **The PPO's Terms of Reference should be reviewed**, particularly in light of the remit of the coroner. Its remit should be more transparently set out, and expectations around its role and duties more carefully managed so as not to create unrealistic expectations.
- The review of the Terms of Reference should have at its heart a testing of its provisions against the Minnesota Protocol on the Investigation of Potentially Unlawful Death, most recently revised in 2016,[20] and in particular whether the PPO satisfactorily meets the elements and principles of investigations set out in paragraphs 22 to 40. The recent Independent Review of the Response to Deaths in Prison Custody in Scotland[21] provides a good example for this human rights-based approach.

[20] See https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf
[21] See Independent Review of the Response to Deaths in Prison Custody p6 (1) WEB PDF.pdf (prisonsinspectoratescotland.gov.uk)

- Once any revised remit of the PPO is agreed, the PPO should seek to communicate this clearly to stakeholders and reiterate their remit in death reports to help, in particular families and coroners, understand their parameters.

Multi-agency co-ordination

- The PPO and Coroners' Society should undertake a joint piece of work to agree to how better to nurture earlier engagement and co-operation and reflect this in an updated Memorandum of Understanding.
- Joint work between the PPO and Coroners' Society should include consideration of how the PPO and Coroners could support each other to amplify messages from Prevention of Future Death reports that reflect the need for changes at the national level.

Wider recommendation:

- The remit of all investigative and inspection bodies with a role in reducing deaths in custody should be mapped to establish overlaps, untapped opportunities for synergies and efficiencies, and opportunities to work more effectively together to amplify key messages, communicate concerns and reduce self-inflicted and other unnatural deaths.

Appendix 1: Summary of recommendations

Systemic issues affecting deaths in custody and the PPO's role (section 3)

1. **PPO reports should reflect the role that 'systemic hazards' have played in the death in prison**.
2. Death investigators should consider what individual prison governors and staff can control and who, beyond the prison, holds responsibility for systemic hazards.
3. **PPO investigations into suicides of those with severe mental illness should highlight the dangers of holding these individuals in prison**. It is hard to see how the PPO's vision that their investigations should make 'custody and community supervision safer' can be properly fulfilled if they do not do so.

Wider recommendations:

4. Prisons should not be used as a place of transition from the courts and police custody into secure healthcare facilities. The PPO and other prison oversight bodies should consider their responsibility in advocating a clear remand pathway from the courts and police custody into least restrictive therapeutic environments for those with severe mental illness who are charged with crimes.
5. Mental health assessments should be available at all times for those in police and court custody to determine the appropriateness of a transfer to prison.
6. Remand to prison should not be used for the severely mentally ill as a means of obtaining reports on fitness to plead. Greater clarity is needed on whose responsibility it is to obtain these reports.
7. Magistrates and Crown Court judges should be educated on the risks of remanding people with severe mental illness to prison and the level of care for this group that can reasonably be expected there. That should include visiting local prisons to better understand why prisons are inappropriate for people with severe mental illness.

Promoting wider change (section 4)

8. Work should be undertaken to **build, clarify and substantiate the evidence base for the PPO's recommendations**.
9. The PPO should consider its role in stimulating policy debates around wider issues including, for example, alternatives to holding severely mentally ill people in prison; the use of remand; mental health services in the community and in prisons.

10. The **PPO should regularly publish thematic reports on self-inflicted deaths** drawing on its recent investigations. Consideration should be given to making this a joint report with other agencies involved in deaths in custody work.

11. The PPO should promote good practice locally, and periodically publish reports to highlight good practice they have encountered in the course of their investigations and promote this, in particular with the Prison Service.

Wider recommendations:

12. **Further work should be undertaken to assess the extent to which, in relation to self-inflicted deaths, recommendations in PPO and Coroner's Prevention of Future Death reports have actually been implemented** as opposed to simply accepted. Where recommendations have not been implemented this should be followed up.

13. Multi-agency consideration should be given to how to create **more robust mechanisms to secure the implementation of evidence-based recommendations,** for example through Her Majesty's Inspectorate of Prisons inspections.

14. More research should be undertaken to understand the impact of investigations into self-inflicted deaths and prison oversight more generally in improving outcomes in prisons.

PPO Ways of Working and Managing Wider Harms (section 5)

PPO ways of working

15. The PPO should **establish and publish the methodology it uses to investigate self-inflicted deaths**. This should transparently set out how evidence is collected, analysed, and assessed.

16. The PPO should set out the evidence base for their conclusions and recommendations more clearly, explaining the basis on which they judge a death to be, or not be, predictable or preventable, taking account of systemic hazards.

17. The PPO should pilot a revised fatal incident report structure and revised recommendations drawing on findings in this report and lesson learning strategies. Consideration should be given to whether the urgency and/or priority of recommendations should be indicated.

18. Further training should be provided to PPO staff to ensure greater consistency in the conduct of investigations and how they interpret their role as investigators. Training should include a mental health component, as well as trauma informed interviewing techniques.

Managing Wider Harms

19. The PPO and the Prison Service should refocus on how prisoner suicide and death investigations affect their staff and adapt their practices accordingly.

20. The PPO **should set out how it seeks to mitigate and minimise the harm that its investigations may cause to both prison staff and its own staff**.

21. Consideration should be given to how further support can be signposted and made available to PPO staff and prison officers affected by suicides to help them better manage primary and secondary trauma.

22. Consideration should be given to whether PPO staff might change roles more regularly and/ or rotate with seconded staff from other departments to reduce the cumulative burden – the 'overload of death' - from investigating self-inflicted deaths over many years.

23. The PPO should provide informal positive feedback to prison staff where they deserve credit and consider how to document and disseminate examples of good practice

24. PPO reports and recommendations should reflect the role that 'systemic hazards' may have played in the self-inflicted death.'

25. Further consideration should be given to an initial stage of 'off the record' interviews with prison and healthcare staff to establish context and help individuals understand the changes within and beyond their control, prior to the established investigatory approach. The report would reflect both parts of the process.

Death investigations: the experiences of families (Section 6)

26. A short, clear explanation of the investigation process and what the PPO, and other agencies involved in investigating suicides in prisons, do (and do not do) should be provided to families of the bereaved at the outset of the investigation, to help manage expectations. This should be provided both verbally and **in printed form**.

27. The needs and wishes of relatives could also shape the remit of the PPO, from acknowledging systemic hazards to enabling families to comment on personal facts to do with the deceased, for example.

28. The PPO should ensure that families are prepared for the receipt of draft and final investigation reports, which may be very upsetting.

29. Signposting to support services should be provided by the PPO.

30. The PPO's bereaved families survey should be reviewed with the aim of improving the response rate and gaining a richer understanding of family 'satisfaction'.

31. Specialist training should be provided to PPO staff on communicating with bereaved families.

Wider recommendations:

32. Further consideration should be given to whether the same prison Family Liaison Officer should be responsible for assisting the family if they are also supporting prison staff at inquest.

33. Coroners should better prepare and signpost families to receive and understand materials including toxicology and pathology reports.

The remit of the PPO and multi-agency working. (Section 7)

Status of the PPO

34. The PPO should be put on a **statutory footing**. We note this was recommended by the Joint Committee on Human Rights as far back as 2004, in particular to provide additional assurance as to the independence of investigations in and in turn their compliance with Article 2 of the European Convention on Human Rights.

35. The PPO's relationship with the **National Preventative Mechanism** (NPM) so be clarified such that past oriented fatal incident investigation reports can better inform death prevention work and prevent ill-treatment in the future – the central role of the NPM as established under OPCAT.

Remit of the PPO

36. Clinical reviews commissioned by the NHS/Healthcare Inspectorate Wales should be more clearly distinguished from PPO Fatal Incident Reports. Current reporting arrangements may wrongly suggest that the PPO has some oversight responsibility for clinical reviews when they lack the clinical expertise for that role. Merely summarising a clinical review is likely to be a poor use of resources.

37. **The PPO's Terms of Reference should be reviewed**, particularly in light of the remit of the coroner. Its remit should be more transparently set out, and expectations around its role and duties more carefully managed so as not to create unrealistic expectations.

38. The review of the Terms of Reference should have at its heart a testing of its provisions against the Minnesota Protocol on the Investigation of Potentially

Unlawful Death, most recently revised in 2016,[22] and in particular whether they satisfactorily meet the elements and principles of investigations set out in paragraphs 22 to 40. The recent Independent Review of the Response to Deaths in Prison Custody in Scotland[23] provides a good example for this human rights-based approach.

39. Once any revised remit of the PPO is agreed, the PPO should seek to communicate this clearly to stakeholders and reiterate their remit in death reports to help, in particular families and coroners, understand their parameters.

Multi-agency co-ordination

40. The PPO and Coroners' Society should undertake a joint piece of work to agree to how better to nurture earlier engagement and co-operation and reflect this in an updated Memorandum of Understanding.

41. Joint work between the PPO and Coroners' Society should include consideration of how the PPO and Coroners could support each other to amplify messages from Prevention of Future Death reports that reflect the need for changes at the national level.

Wider recommendation:

42. The remit of all investigative and inspection bodies with a role in reducing deaths in custody should be mapped to establish overlaps, untapped opportunities for synergies and efficiencies, and opportunities to work more effectively together to amplify key messages, communicate concerns and reduce self-inflicted and other unnatural deaths.

[22] See MinnesotaProtocol.pdf (ohchr.org)
[23] See Independent Review of the Response to Deaths in Prison Custody p6 (1) WEB PDF.pdf (prisonsinspectoratescotland.gov.uk)

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