University of Nottingham
UK | CHINA | MALAYSIA

Improving prisoner death investigations and promoting prison safety

Policy Brief - February 2023

Summary

Hundreds of prisoners die every year in England and Wales, resulting in tremendous harms and costs. These deaths will almost always be investigated by the Prisons and Probation Ombudsman (PPO) after a police investigation and before a Coroner's inquest. PPO reports are usually produced far more quickly than inquest findings, hence could be a valuable catalyst for improved prison safety. The sustained high numbers of prisoner deaths in England and Wales suggest this potential is not being realised.

This guide reports on extensive qualitative research carried out with PPO staff, prison staff, coroners and bereaved families. It also highlights the policy implications of the research findings.

About this research

Dr Philippa Tomczak and Sara Hyde carried out in-depth, qualitative fieldwork through semi-structured interviews with 16 PPO staff, 8 prison governors, 11 Group Safer Custody Leads, 9 coroners and a bereaved family member in 2019-20. In addition, Dr Tomczak reviewed 145 PPO fatal incident reports between 2017 and 2020.

The information in this guide comes from this qualitative research, which is reported fully in Shalev and Tomczak (2023) *Improving prisoner death investigations and promoting change in prisons: A findings and recommendations report.*[1] This research was funded by the ESRC Impact Acceleration Account, SPF-QR funding from Research England and UK Research and Innovation [grant number MR/T019085/1].

Key policy recommendations

1. Prisoner death investigations should highlight 'systemic hazards'.
2. The Prisons and Probation Ombudsman (PPO) requires new *Terms of Reference* that transparently and accurately define the PPO's remit and activities. A short, clear explanation of the investigation process exemplifying what the PPO do, and do not do, should also be provided publicly and disseminated to bereaved families and coroners, both verbally and in print.
3. The PPO should publish the methodology it uses to investigate prisoner deaths, transparently setting out the evidence base for its judgments and recommendations.

UKRI UK Research and Innovation

LUNG

prisonDEATH
DEATHS IN PRISON WORLDWIDE

Findings and recommendations

1. Prisoner death investigations should highlight 'systemic hazards'

The November 2022 inquest into the death of 25-year-old Alex Braund, a remand prisoner at HMP Nottingham, found that Mr Braund's – ultimately fatal – symptoms of pneumonia were overlooked for four days. Crucially, the inquest highlighted that a *single nurse and a single senior healthcare assistant were responsible* for providing medical care to the entire local prison, holding over *800 prisoners* [2] at the time of his death on 10th March 2020. The Officer on Mr Braun's wing was responsible for more than 70 prisoners.

> "Self-inflicted deaths occur most often in the local prison estate. The same prisons are always in the press, your Pentonvilles, Wandsworth, Liverpool, Leeds, Nottingham. It's because they are all local prisons. We are bringing people in from the community with substance misuse, with mental health, with various other factors that they are struggling with and we haven't got half the staff that we had"
> – Prison Governor

In contexts such as this, it is inevitable that prison healthcare will continue to be inadequate and that prisoners will continue to die preventable deaths, no matter how frequently prison staff are reminded to e.g. follow emergency response codes (a compliance recommendation that the PPO very regularly repeat). And yet, the PPO's prisoner death investigations currently examine and make recommendations on policy and procedural compliance by prison staff, very rarely highlighting systemic issues such as those which contributed to Alex Braund's death.

Section 26 of the United Nations' 2017 *Minnesota Protocol on the Investigation of Potentially Unlawful Death*[3] states that investigations should seek to identify policies and systemic failures that may have contributed to a death. In an adjacent context, the Care Quality commission's 2016 review of NHS trust investigations into patient deaths in England '*Learning, candour and accountability*'[4] similarly recommended focussing investigations on system analysis rather than individual errors. It is time for prisoner death investigations to start naming the underpinning systemic issues such as too many prisoners,[5] record numbers of prisoners on remand[6] and too few staff.

2. The PPO requires new *Terms of Reference* that transparently and accurately define the PPO's remit and activities. A short, clear explanation of the investigation process exemplifying what the PPO do, and do not do, should also be provided publicly and disseminated to bereaved families and coroners, both verbally and in print.

> "The PPO report took about 12 months. The draft said you could ask any questions in writing. So we did. We had quite a lot of questions, I wrote a full A4 list and their sister did the same. And then we waited for the final copy and answers. Out of two A4 lists we got one or two questions answered. We felt that had been a pointless waste of time."
> – Bereaved partner

The PPO's current *Terms of Reference* are the first link on its online homepage. These *Terms of Reference* are worded expansively but vaguely, using inaccessible language throughout. The PPO ostensibly seeks: "to ensure […] that the full facts are brought to light and […] examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence".[7]

45 interviews with prison death stakeholders

145 PPO fatal incident reports

In practice, the PPO rarely engages with issues not covered by local and national prison policies, but they do not make this clear. It is currently confusing that PPO reports may not investigate or answer bereaved families' questions (e.g. about why their ill relative was not hospitalised rather than imprisoned[8]) and that systemic issues are not highlighted, such as the remanding of people with severe mental illness to prison.[9]

> "Sometimes what [bereaved families] want looked at is absolutely nothing to do with our remit. We had one where the family were very upset that he had been recalled to prison, from the community. They wanted that investigated but that is outside our remit."
> - Ombudsman

The PPO should either broaden its activities to reflect its existing *Terms of Reference*, or more accurately reflect its focus on investigating prison staff compliance with local and national prison policies. Such transparency will have widespread benefits, being particularly useful for the understanding of coroners, bereaved families and prison staff, and will avoid creating unrealistic expectations.

3. The PPO should publish the methodology it uses to investigate prisoner deaths, transparently setting out the evidence base for its judgements and recommendations

Investigations need to follow a clear and consistent process, underpinned by a robust, transparent methodology. Her Majesty's Inspectorate of Prisons sets out the criteria it uses to inspect prisons in its 'Expectations' documents',[10] but the PPO publicly provides only a cursory explanation of how it investigates prisoner deaths.

No detailed methodology is 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 prisoner deaths. The PPO should also clearly explain the basis upon which they judge a death to be (un)predictable or (un)preventable.

> "There are uncertainties as to the standard of proof. I'm from a legal background, so I'm concerned to establish that we prove everything, the balance of probabilities, whereas I've no idea what standard the PPO works to because *it's never made plain in their investigations.* I don't know how they conduct things, how much they press or challenge."
> - Coroner

Conclusion

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. Acknowledgment of systemic hazards, new *Terms of Reference* and an explicit methodology would be a significant contribution.

Contact the researcher

Dr Philippa Tomczak[11]

Principal Research Fellow, Faculty of Social Science, University of Nottingham.
Email:Philippa.Tomczak@nottingham.ac.uk
Visit: www.safesoc.co.uk

[1] Shalev, S. and Tomczak, P. (2023) Improving prisoner death investigations and promoting change in prisons: A findings and recommendations report. https://doi.org/10.17639/q0mg-9b58
[2] https://dpglaw.co.uk/alex-braund-jury-finds-continuous-failure-to-provide-adequate-healthcare-contributed-to-death/; https://www.theguardian.com/society/2022/dec/06/parents-of-man-left-to-die-in-prison-say-care-failures-will-haunt-them-for-ever
[3] https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf
[4] Learning, candour and accountability | CQC Public Website
[5] Tomczak, P., Quinn, K., et al. (forthcoming) (Re)constructing individualised prisoner death investigations: a case study from England and Wales
[6] https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-april-to-june-2022/offender-management-statistics-quarterly-april-to-june-2022
[7] PPO (2021) *Terms of Reference*, p. 9-10 https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/12/PPO-2021-Terms-of-Reference.pdf
[8] Tomczak, P. and Cook, E. A. (2022) Bereaved family 'involvement' in (prisoner) death investigations: whose 'satisfaction'? *Social and Legal Studies* OnlineFirst
[9] Tomczak P (2022) Highlighting 'risky remands' through prisoner death investigations: people with very severe mental illness transitioning from police and court custody onto remand. *Frontiers in Psychiatry 13.* https://doi.org/10.3389/fpsyt.2022.862365
[10] See Our Expectations (justiceinspectorates.gov.uk).
[11] Thank you to Sharon Shalev, Tom Kemp, Ruth Elmer, Chris Sims and Alex Elliott for supporting this publication.
Image credit: Dino Dimopoulos from LUNG's Woodhill.