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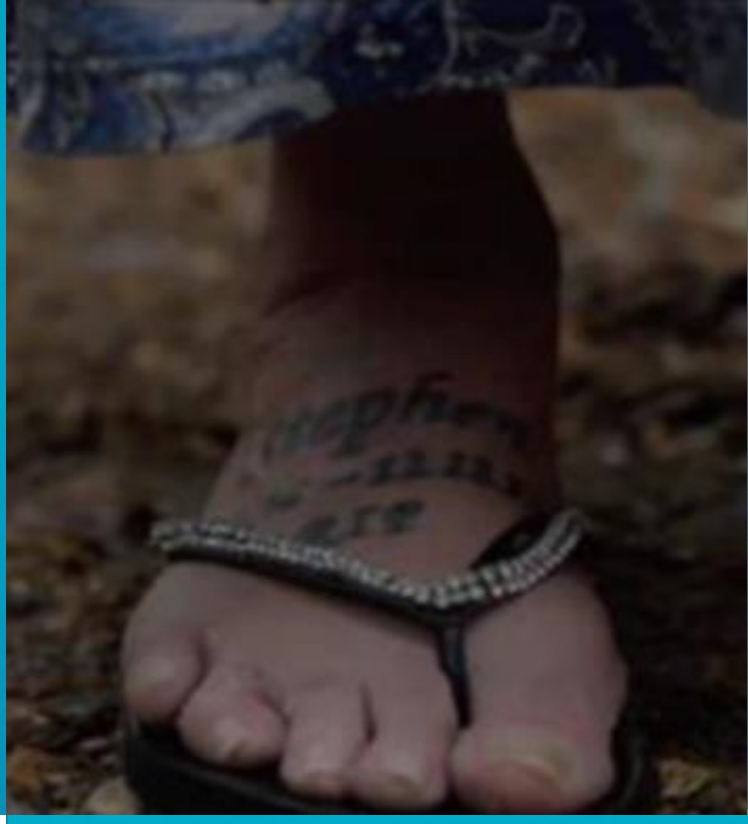
Improving death investigations to promote safety

Case study: Prisoner deaths

Policy Brief - September 2023



Summary

Ending premature and preventable deaths is key to UN Sustainable Development Goal 3: *Ensure healthy lives and promote well-being for all at all ages*. Death investigations hold potential to improve public health and safety yet have not garnered attention reflecting their importance and harm reduction potential (inter)nationally. This is especially true of deaths in custody.

This briefing considers how death investigations could more effectively improve safety, using extensive qualitative research regarding prisoner death investigations as a case study.[1] Hundreds of prisoners die every year in England and Wales, creating tremendous harms and costs. Prisoner deaths are almost always investigated by the Prisons and Probation Ombudsman (PPO) and clinical reviewers, after a police investigation and before a coroner's inquest. PPO reports and clinical reviews could catalyse much-needed safety improvements relatively rapidly. Unfortunately, their potential to spark meaningful change remains unrealised.

Key research findings and recommendations are reported in Shalev and Tomczak (2022) *Improving prisoner death investigations and promoting change in prisons: a findings and recommendations report*. This policy brief accompanies the *Improving prisoner death investigations and promoting prison safety* brief.

Key policy recommendations

1. To enhance safety, all death investigations should highlight '**systemic hazards**'

2. All investigating bodies require **Terms of Reference** that transparently define their remit and activities. Short, clear explanations exemplifying what each body does **and does not do** should be publicly available

3. All investigating bodies should publish the **methodology** they use to investigate deaths, transparently setting out the **evidence base** for their judgments and recommendations

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Findings and recommendations

1. To enhance safety, all death investigations should highlight 'systemic hazards'

> Bereaved mother Jo Billington, regarding the July 2023 NHS inquiry into the Birmingham stabbings: "This report […] has some very weak recommendations that fail to get to the heart of what went wrong here".[2]

A growing academic evidence-base warns against reviews that emphasise policy and procedure compliance whilst lacking due regard for the *contexts* in which practice occurs.[3] The 2016 Care Quality Commission review[4] of NHS patient death investigations advocated focus on *system analysis* rather than individual errors. The 2017 United Nations *Minnesota Protocol*[5] directs investigations to identify policies and *systemic failures* that may have contributed to deaths.

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.*[6] The wing officer was responsible for over 70 prisoners. In such contexts, healthcare will inevitably be inadequate and preventable deaths will recur, no matter how frequently prison staff are reminded to e.g. follow emergency response codes (a policy compliance recommendation that the PPO very regularly repeat).

The PPO's 'independent' prisoner death investigations currently seek "to understand what happened, to correct injustices and to identify learning […] so that the PPO contribut(es) to safer, fairer custody."[7] In practice, the PPO and clinical reviewers currently make recommendations regarding prison staff compliance with organisational policy and procedures, very rarely illuminating systemic issues. It is time for prisoner death investigations to start naming underpinning systemic issues: too many prisoners,[8] record numbers of prisoners on remand[9] and too few staff.

2. All investigating bodies require Terms of Reference that transparently define their remit and activities. Short, clear explanations exemplifying what each body does and does not do should be publicly available

> Bereaved partner: The [draft] PPO report […] said you could ask any questions in writing. […] We had quite a lot of questions. […] We waited for […] answers. […] Out of two A4 lists we […] got one or two questions answered. […] **We felt that had been a pointless waste of time.**

In child fatality reviews, clear Terms of Reference (i.e. remit and purpose) are a central plank of the RoSE investigation model which offers "singular promise" to produce "shared learnings […that…] can promote children's safety and wellbeing".[10] Regarding domestic homicide reviews, stakeholder disagreements regarding investigation purpose(s) can undermine knowledge generation and wider applications.[11]

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".[12] In practice, the PPO rarely engages with issues beyond local and national prison policy compliance, but this focus is not made clear. It is currently confusing that PPO reports may not investigate bereaved families' questions (e.g., about why their ill relative was imprisoned rather than hospitalised)[13] and

- **45 interviews with prison death stakeholders**
- **145 PPO fatal incident reports**
- **Sense testing findings through multidisciplinary literature review**

that contextual issues are not highlighted, such as the systematic remanding of people with severe mental illness to prison.[14] The PPO should either broaden its activities to reflect its existing Terms, or more accurately explain its focus on investigating prison staff policy compliance. Such transparency will avoid creating unrealistic expectations and facilitate better understanding of the investigations amongst coroners, families and prison staff.

3. All investigating bodies should publish the methodology they use to investigate deaths, transparently setting out the evidence base for their judgments and recommendations

> Coroner: There are uncertainties as to the standard of proof. […] I'm from a legal background, so I'm concerned to […] 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.

Investigations must follow a clear and consistent process, underpinned by a robust, transparent methodology. For child fatality reviews, the 'CLEAR' approach to recommendations has been advocated, being based on multiagency collaboration.

The approach includes: making a well-informed **C**ase for change, promoting **L**earning through good practice, drawing on **E**vidence (including knowledge of the contexts in which recommendations are to be implemented), **A**ssigning responsibility for implementation, and being amenable to **R**eview.[15] Whilst adopting this approach would not be a silver bullet, explication of process and methodology is valuable in investigations involving multiple agencies.

The PPO publicly provides only a cursory explanation of how it investigates prisoner deaths.[16] No detailed methodology is available and recommendations are not underpinned by an **evidence base** on which changes are most likely to contribute to improved safety. The PPO should also clearly explain the basis upon which they judge a death to be (un)predictable or (un)preventable.

Conclusion

Death investigations are traumatic for all involved. Evaluation of public inquiries after homicide concluded that detriment to those "awaiting and undergoing the process […] can only be weighed against the effectiveness of […] recommendations".[17] Transparency is imperative to reduce harms to all involved. Systemic analysis is vital to mitigate the likelihood of recurrence. All death investigations should be produced under explicit *Terms of Reference* and methodologies.

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[1] Prof Philippa Tomczak and Sara Hyde carried out in-depth, qualitative fieldwork including semi-structured interviews with 16 PPO staff, 8 prison governors, 11 Group Safer Custody Leads, 9 coroners and a bereaved family member (2019-20). Verbatim documentary work was undertaken by LUNG with 3 further bereaved families (*WOODHILL*, 2021; *WOODHILL*, 2023). Prof Tomczak also reviewed 145 PPO fatal incident reports between 2017 and 2020. Research was funded by the ESRC Impact Acceleration Account, Research England SPF-QR funding and UK Research and Innovation [*grant MR/T019085/1*].
[2] Sky News (2023) Birmingham knife attacks.
[3] Firmin C (2018) Contextualizing case reviews. *Child & Family Social Work 23*(1): 45–52.
[4] CQC (2016) *Learning, candour and accountability*.
[5] OHCHR (2017) *Minnesota Protocol*.
[6] DPG law (2022) *Alex Braund inquest*; Guardian (2022) *Parents say care failures will haunt them*.
[7] PPO homepage.
[8] Tomczak P, et al (forthcoming) *Reconstructing prisoner death investigations.*
[9] MoJ (2023) *Offender management statistics quarterly.*
[10] Raman et al (2017: 290) Review of serious events in cases of (suspected) child abuse and/or neglect. *Child Abuse & Neglect, 70*: 283-291.
[11] Cook EA et al (2023) Applying Principles of Research Integrity and Ethics in Domestic Violence Fatality Review. *Journal of Family Violence*, 38: 1015–1027; Rowlands JH (2023) *Exploring the potential and peril of domestic homicide reviews* (Doctoral dissertation, University of Sussex).
[12] PPO (2021: 9-10) *Terms of Reference*.
[13] Tomczak P and Cook EA (2023) Bereaved family 'involvement' in (prisoner) death investigations: whose 'satisfaction'? *Social & Legal Studies 32*(2): 294-317.
[14] Tomczak P (2022) Highlighting "Risky Remands" Through Prisoner Death Investigations. *Frontiers in Psychiatry 13.*
[15] Buckley H and O'Nolan C (2014) Child death reviews. *Child Abuse Review 23*(2): 89-103.
[16] Her Majesty's Inspectorate of Prisons sets out its criteria in its 2021 *Expectations*.
[17] Peay J (1996: 30) 'Themes and questions: the inquiry in context', p 9-38 in Peay J (Ed) *Inquiries after Homicide*. London: Duckworth.

[18] Thank you to Gillian Buck, Elizabeth Cook, Ruth Elmer, Alex Elliott, Tom Kemp, James Rowlands and Sharon Shalev for supporting this publication

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