





### **Event Report**

# Improving prisoner death investigations and promoting prison safety

Cholmondeley Room and Terrace, House of Lords Tuesday 24 October 2023, 12.15 – 14.30

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Social media hashtag #deathinprison

This work was supported by: UKRI Future Leaders Fellowship MR/T019085/1 (2020-24) and the University of Nottingham Institute for Policy and Engagement Small Grants (2021).

#### **Agenda**

	Time	Title & Speaker
Arrivals	12.15 –	
	12.25	
Welcome &	12.25 -	Lord Harris of Haringey and Professor Philippa Tomczak,
Introduction	12.35	University of Nottingham
Introduction		
Policy Brief	12.35 -	Professor Philippa Tomczak, University of Nottingham
	12.50	
WOODHILL short	12.50 -	
film introduction	13.15	Dr Gillian Buck, University of Chester
and screening		
Families'	13.15 –	Matt Woodhead, LUNG theatre and the Woodhill families'
reflections	13.30	group
Refreshment	13.30 -	
break	13.45	
Q&A	13.45 -	Sara Hyde, University of Nottingham
	14.25	
Close	14.25 -	
	14.30	

#### Introduction

The *Improving prisoner death investigations and promoting prison safety* event was hosted at the House of Lords by Professor Philippa Tomczak and the University of Nottingham SAFESOC team, on the 24<sup>th</sup> October 2023. The event showcased a verbatim film documenting the lived experience of a family bereaved by prison suicide and facilitated reflections and provocations from the *Woodhill Families' Group* – a collective of families who have lost loved ones in prison. Drawing on research by Professor Philippa Tomczak into prison death investigations, the event also launched a short policy brief for prison regulators and policymakers.

The event was attended by over 70 representatives including parliamentarians, policymakers, the Prisons and Probation Ombudsman, Inspectors and Coroners, prison staff, health and social care staff, voluntary organisations, academics and people who have been personally impacted by deaths in prison.

#### Summary of event content

Lord Harris, event sponsor, introduced the event noting the importance of learning lessons from deaths and listening to families impacted. He explained his long-standing interest in this topic and reflected on his leadership of *The Harris Review* (2015) an Independent Review into Self-inflicted Deaths in Custody of 18–24-year-olds, which highlighted a familiar problem of lessons not being learned and a need for ministers and senior leaders to take responsibility for implementing changes.

Professor Philippa Tomczak thanked Lord Harris for sponsoring the event and the audience for their attendance. She outlined the format of the afternoon, the emotive nature of the materials and experiences being presented, and invited attendees to look after themselves and one another during discussions.

The first paper, from Professor Philippa Tomczak, introduced the *Improving death investigations to promote safety policy brief*. The brief centres prisoner deaths as a case study, but concludes that all formal death investigations could benefit from:

- 1. Highlighting '**systemic hazards**' so that factors (such as prisoner populations and staffing numbers) which feature across death reports can be addressed.
- 2. Clear **Terms of Reference** that transparently and publicly define their remit and activities and explain what each body **does and does not do**.
- 3. Publication of the **methodology** used to investigate deaths, transparently setting out the **evidence base** for judgments and recommendations.





Improving death investigations to promote safety

Case study: Prisoner deaths

Policy Brief - September 2023



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. I 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) <u>Improving prisoner death investigations and promoting change in prisons: a findings and recommendations report.</u> This policy brief accompanies the <u>Improving prisoner death investigations</u> and promoting prison safety brief.

## Key policy recommendations

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

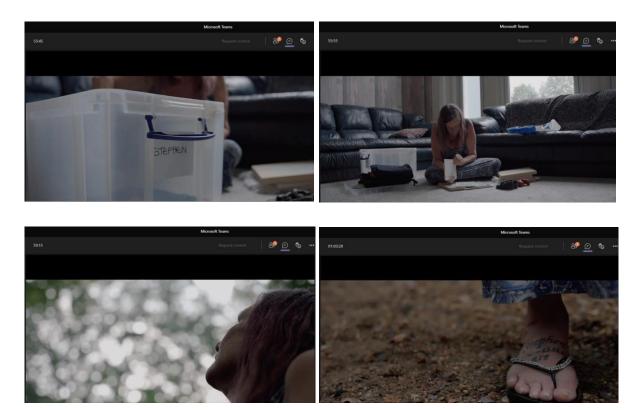






Dr Gillian Buck introduced the moving and important film "WOODHILL", produced by Lung Theatre Company and featuring Janet Farrar, whose son Stephen died in prison in 2013. When somebody dies in prison, their loved ones can experience 'disenfranchised' grief, as their grief may not be openly acknowledged, socially supported or publicly validated. (Abbott et al., 2023). Such trauma is embodied and difficult to express in words (Murray et al., 2019), yet collaborative film can offer a powerful form of visual representation which can centre lived experiences and influence understanding, potentially inspiring broader social change (Paget, 2010). Telling these stories can also help to 'validate' lives (Maruna and Liem, 2021), redressing the detachment of people from their histories and social contexts, which can occur in official accounts.

These screenshots depict Janet remembering Stephen and talking about how he walks with her as she tries to move forward:



Following the film, Matt Woodhead and Helen Monks (co-directors of LUNG) facilitated reflections from Janet, Lee, Linda and Carole, from the *Woodhill Families Group* whose loved ones also died in prison and whose experiences have informed the critically acclaimed *Woodhill* theatre production about prison suicide. Often those most motivated to improve prison safety are those directly affected and campaigns by families of prisoners have instigated changes in prisons (Tomczak, 2022). The *Woodhill families* spoke of their family members' unanswered cries for help, of insufficient mental health and self-harm assessments, of too few (specialist) staff, of unmet addiction and mental health needs, and of their unanswered questions following deaths.

Following a question-and-answer session, Professor Philippa Tomczak thanked the families, presenters and audience members and invited attendees to complete a short questionnaire – some of the event feedback is included below.

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

#### References

- Abbott, L., Scott, T., & Thomas, H. (2023). Compulsory separation of women prisoners from their babies following childbirth: Uncertainty, loss and disenfranchised grief. *Sociology of Health & Illness*, *45*(5), 971-988.
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- Maruna, S., & Liem, M. (2021). Where is this story going? A critical analysis of the emerging field of narrative criminology. *Annual Review of Criminology*, *4*, 125-146.
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- Paget, D. (2010). Acts of commitment: Activist arts, the rehearsed reading, and documentary theatre. *New Theatre Quarterly*, 26(2), 173-193.
- Tomczak, P. (2023). *Improving death investigations to promote safety Case study:*\*\*Prisoner deaths. Available from: <a href="https://www.safesoc.co.uk/wp-content/uploads/2023/10/improving-death-investigations-to-promote-safety-policy-brief-sept-23-3.pdf">https://www.safesoc.co.uk/wp-content/uploads/2023/10/improving-death-investigations-to-promote-safety-policy-brief-sept-23-3.pdf</a>
- Tomczak, P. (2022). Reconceptualizing multisectoral prison regulation: Voluntary organizations and bereaved families as regulators. *Theoretical criminology*, 26(3), 494-514.

#### **Event feedback**

Lord Harris of Haringey, Toby Harris (Sponsor and SAFESOC Advisory Board member): "Extremely powerful day, especially the testament from the families". In 2015, when 'Changing prisons, saving lives' reviewed the self-inflicted deaths of 83 young adults, it was clear that operational staffing levels were not adequate. Prison overcrowding and staffing have got worse since then. Prison should be a last resort and much more needs to be done to support young people before they come into the criminal justice system. Unfortunately, political rhetoric remains stuck on putting more people into prison, for more offences and for longer.

**Baroness Royall of Blaisdon:** Listening to the testimonies of those with a family member who had died by suicide in prison was powerful, devastating. It's clear that action must be taken to prevent further suicides in prisons. Yesterday's event was invaluable in raising awareness amongst those who could make a difference.

**David Shipley – Journalist:** This was such a powerful event, rightly centred around the experiences and insights of the families of prisoners who died at HMP Woodhill. The policy paper represents an important effort to ensure that inquests and PPO investigations don't just keep repeating the same findings while nothing changes. The three recommendations in the policy paper should be enacted.

#### Selected survey responses

#### What will you put into practice as a result of this event?

- Think about the impact on family and friends even more so.
- More thinking about systemic analysis.
- Consider coroner reports as a prison stakeholder and organise more public engagement events for discussion and feedback on research.
- Engage with the PPO about the format of their recommendations and encourage learning from the themes of the deaths.
- Consider deaths under community supervision once people leave prison.
- Consider failures by prison staff to not see the cries of help from prisoners.
- Pay closer attention to prison reform legislation.
- Share this work with the people I work with.
- Think about film as a way of conveying research messages.

#### Do you have any feedback on the film?

- Amazingly moving. Absolutely brilliant. So impactful and thought-provoking.
- Thought-provoking and powerful the images and use of dance and music, in combination with the narration, worked extremely well.
- Powerful, incredibly moving, I hope it will be shown to magistrates and judges.
- The film is an uncomfortable watch, which is what it should be. It is thought provoking and emotive and allowed professionals to experience the situation from a family member perspective providing greater awareness of what it is like to be on the receiving end of 'the system'.
- It was pitched perfectly. It was very moving and well produced.
- Very powerful! great courage from the bereaved families.

#### Do you have any feedback on the overall event?

- Hugely important.
- Absolutely brilliant. Great venue/arrangements/organisation/content.
- It was one of the best events I have ever been to. The presentations were very informative, and the venue was fantastic also.
- Very well done, great speakers, video, food, and made some good contacts, families were centred in a way that felt authentic and contributed to our understanding of the issues.
- Loved it.
- Very smoothly run afternoon.

#### What did you find most useful?

- Seeing the film, meeting others working in a similar field to myself.
- Sustained arguments re the need for systemic analysis, hearing from family members, the film.
- The diversity of the audience and their range of interests related to imprisonment. It emphasised the importance of academic engagement with stakeholders and the public in person.
- The networking was helpful, hearing other professionals' experiences and thoughts.
- Hearing from the families. I regularly visit prisons and their feedback will help me look at things differently (for the better).
- Loved every moment.
- Meeting with the families which brought a realness to the statistics.
- The stories from the families.
- Q&A was great, could have had another 30 minutes but such is life.



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