(Re)constructing Prisoner Death Investigations: A Case Study of Suicide Investigations from England and Wales

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Because states must rebut the presumption of responsibility, all prisoner deaths must be investigated. These investigations frequently illustrate the tip of an iceberg of rights abuses and systemic hazards but have largely escaped analysis in prison-monitoring scholarship. Focusing on suicides, we assemble some of the first evidence illustrating how the staff of the Prisons and Probation Ombudsman, who investigate prisoner deaths in England and Wales, seek to prevent further deaths. Ombudsman investigations are widely regarded as ineffective, yet there are competing constructions regarding why this is and what could be done to improve outcomes. As a result of organizational norms and constraints, ombudsman staff have offered narrow accounts of prisoner suicides, focusing on the failure of frontline staff to comply with prison policies. By contrast, prison staff and coroners have focused on systemic hazards or "accidents waiting to happen," including imprisoning people with severe mental illness, illegal drugs, unsafe facilities, and inadequate staffing. These differing constructions lock penal actors into an unproductive cycle of blame shifting that contributes to high suicide numbers. We reconceptualize prisoner deaths as occurring at the intersection of systemic hazards, organizational contexts, and individual errors. We hope that this reconceptualization facilitates broader investigations that are more likely to prevent prisoner deaths.

INTRODUCTION

Mortality rates for the world's eleven million prisoners are as much as 50 percent above those in outside populations (UN Office of the High Commissioner for Human

Rights [2019], 9).[1] Prisoner deaths are rising globally due to growing prison populations, increasing sentence lengths, increasing numbers of older prisoners (Roulston et al. [2021]), and elevated self-inflicted death rates amongst prisoners (Zhong et al. [2021]). Yet, aside from specific attention to the death penalty/judicial executions (Greenberg and West [2008]), around the world, "it is a widely overlooked problem that in many prisons deaths are frequent" (Gaggioli and Elger [2017], 35). Prisoner deaths frequently illustrate the tip of an iceberg of rights abuses, systemic hazards, and, indeed, risks to societal safety. Prisoners are unable to leave environments that concentrate "poverty, conflict, discrimination and disinterest" and imperil the health and well-being of prisoners and staff (World Health Organization [2000], 11). The less safe the prison, the greater the risks for prisoners and communities outside. Research indicates that poorer prisoner health (Link, Ward, and Stansfield [2019]) and poorer prison social climates (Auty and Liebling [2019]) correlate with higher reoffending rates. Moreover, prison health is public health (McLeod et al. [2020]). Prisons are a vector for (community) transmission of infectious diseases, disproportionately impacting marginalized communities (Kinner et al. [2020]). In turn, every prisoner death investigation provides a window to identify, organize, and apply learning that could safeguard prisons and societies (Tomczak and McAllister [2021]; Tomczak [2022]a).

All deaths in compulsory state detention threaten the fundamental human right to life—hence, states must rebut the presumption of responsibility for detainee deaths, and all prisoner deaths must be investigated (UN Office of the High Commissioner for Human Rights [1988], Principle 34). In *Eshonov v. Uzbekistan*, the United Nations (UN) Human Rights Committee has highlighted this obligation: "A death in any type of custody should be regarded as prima facie a summary or arbitrary execution, and there should be a thorough, prompt and impartial investigation to confirm or rebut the presumption, especially when complaints by relatives or other reliable reports suggest unnatural death" (see also Rule 71 of the UN Standard Minimum Rules for the Treatment of Prisoners).[2] This obligation has been enacted differently across regions. In the Council of Europe's forty-seven member states, for example, all deaths in compulsory state detention that are unexplained or related to violence and self-harm engage Article 2 of the European Convention on Human Rights (ECHR), which includes a duty to investigate potential violations of the right to life (Scott Bray and Martin [2016]).[3] In October 2021, deaths in custody were assigned as one of four priority areas by the UN special rapporteur on extrajudicial, summary, or arbitrary executions. He stressed the role of death investigations in preventing and resolving deaths worldwide, stating: "Most deaths in custody are preventable. However, they are seldomly investigated properly … which helps perpetuate this tragedy" (UN Human Rights Council [2021], para. 8).

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1. Studies highlight that the mortality rate differentials vary, for example, between countries (Tomczak and Mulgrew [2023]), different types of prisons (Patterson [2010]), with prisoner characteristics (Fazel and Baillargeon [2011]) and with causes and manners of death (Braithwaite et al. [2021]).

2. *Olimzhon Eshonov v. Uzbekistan*, Communication no. 1225/2003, UN Doc. CCPR/C/99/D/1225/ 2003 (2010), para. 9.2; UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), adopted by UN General Assembly Resolution 70/175, December 17, 2015.

3. Convention for the Protection of Human Rights and Fundamental Freedoms, November 4, 1950, 213 UNTS 221.

Prisoner death investigations have largely escaped the attention of scholars examining prison monitoring, which has become a key feature of international human rights norms and practice (see O'Connell and Rogan 2022). Prisoner death investigations, underpinning legal frameworks, and evidence bases have not attracted attention reflecting their importance and harm reduction potential and remain ripe for development across legal frameworks (Correctional Service Canada 2018; Tomczak and McAllister 2021). Given the harms and costs of prisoner deaths (Roulston et al. 2021; Banwell-Moore et al. 2022), establishing how investigations could play a more effective preventative role is an urgent, essential task. We assemble some of the first evidence illustrating how investigators construct prisoner deaths in England and Wales and explore the implications of investigators' constructions. Whilst our findings have relevance across investigations into all prisoner deaths, our research focuses on suicides. Although our findings were generated in one jurisdiction, with careful attention to contextual differences, they could inform prisoner death investigations worldwide. The United Kingdom has dense detention-monitoring approaches, which it actively promotes overseas (Tomczak 2022a). Nevertheless, in England and Wales, prisoner self-inflicted death rates more than doubled between 2012 and 2016, when they hit record numbers (Tomczak 2018). Prisoner suicide negatively affects prisoners, staff, and families and drains hundreds of millions of pounds sterling from public funds annually (Tomczak 2018).[4]

When a prisoner dies in prison in England and Wales (including public and private prisons),[5] three official investigations take place: by the police, by the ombudsman, and by the coroner. The primary investigation is by the police, who examine whether evidence could support a criminal prosecution, such as for homicide or corporate manslaughter. Such prosecutions are very rare, but a criminal trial would fulfill the investigative obligation under Article 2 of the ECHR, removing the requirement for further investigations (Tomczak 2018). The findings of the police investigation are often shared with the other two investigating bodies, although all three investigations frequently run in parallel (Tomczak 2018). The second investigation is by the Prisons and Probation Ombudsman (PPO), a national organization extended in 2004 to help meet the provisions of Article 2 (Owen and Macdonald 2015).[6] The PPO produces a draft investigation report that informs, although does not determine, the third investigation—the coroner's inquest—and provides interim findings to families and services approximately twenty-six weeks after the death, if the investigation runs on time (PPO 2021).

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4. The costs and harms of prison suicides includes loss of life, suffering of families, direct staffing costs (for example, police investigation, Prisons and Probation Ombudsman's [PPO] investigation, coroner's investigation, legal representatives for prison staff), indirect staffing costs (for example, sickness and stress absence, counselling for staff and prisoners), compensation payments to families and contributions to funeral costs (Howard League 2016).

5. This includes Category B or local prisons, which are akin to jails in the United States.

6. The PPO sits within a broader prison oversight structure in England and Wales that comprises local Independent Monitoring Boards, the national Inspectorate of Prisons, and international oversight by European and United Nations (UN) committees. The United Kingdom has ratified the UN's Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, December 10, 1984, 1465 UNTS 85, but the PPO is not a member of the National Preventative Mechanism.

PPO reports are also made publicly available after the inquest has concluded,[7] which can take several years. In England and Wales, as the state may bear responsibility for all prisoner deaths (UN Office of the High Commissioner for Human Rights 1988, Principle 34), its investigative obligation under Article 2 is normally fulfilled through a coroner's inquest that seeks to establish who the deceased was and by what means and in what circumstances they died (McIntosh 2016).[8] Inquests are underpinned by legislation and case law (Owen and Macdonald 2015), but coronial practice is undertaken locally and funded by local authorities (Baker 2016; Angiolini 2017).[9] Although the PPO shares information with coroners, both sets of investigation findings are published separately, produced with different aims and methodologies, and may bear little relation to one another (Tomczak 2022b; Tomczak and McAllister 2022). Inquest verdicts may be shared with police and the PPO, but there is often limited coordination or interaction between the investigating bodies.[10]

In this research, we focused on the national PPO. PPO recommendations are produced across all prisons in England and Wales, often significantly faster than inquests are concluded, and PPO recommendations alone inform the follow-up monitoring undertaken by His Majesty's Inspectorate of Prisons (Tomczak 2018).[11] Moreover, coronial practice is undertaken locally by eighty-five area coroners who have varying experience in prisons (Baker 2016; Angiolini 2017). Whilst further research on coroners' inquests would also be valuable, the national, and generally faster, PPO recommendations appear most likely to impact prison safety and, hence, was chosen as our focus.

The PPO (2022, 76) has a substantial annual budget of almost six million pounds sterling but has no statutory basis and operates under expansively worded Terms of Reference and Memoranda of Understanding (Owen and Macdonald 2015; Tomczak and McAllister 2022). The PPO's (2021, 11) investigation aims include "ensur[ing] ... that the full facts are brought to light and ... examin[ing] whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence." But, by its own analysis, the PPO struggles to impact prisoner death numbers and frontline practice (PPO 2019, 11). Legalistic solutions to

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7. "Fatal Incident Report," *Prisons and Probation Ombudsman*, n.d., https://www.ppo.gov.uk/document/fii-report/.

8. Many (former) British Commonwealth states also utilize coronial inquests to investigate unnatural deaths (Spillane et al. 2019; Evans 2021). Although prisoner death investigations are mandated under international law, little is known about investigating agencies and their processes and how these (fail to) intersect with local, national, and international oversight structures. Which investigations inform coroners' inquests? In Canada, for example, prisoner deaths appear to be investigated externally by the police, the Office of the Correctional Investigator, coroners, and occasional Royal Commission inquiries (Razack 2012; Office of the Correctional Investigator 2014; Kerr 2017).

9. Organizations that are officially responsible for public services and facilities (for example, education, planning, social services, roads, fire, public health, crime prevention) in particular locales.

10. There is no central collation, analysis, or publication of coroners' prevention of future death reports or narrative verdicts, meaning that there is no national learning across detention institutions (Coles and Shaw 2012), although it is also important to question the value and efficacy of current investigation findings.

11. His Majesty's Inspectorate of Prisons is an independent inspectorate that reports on conditions for, and treatment of, those in prisons, young offender institutions, and immigration detention facilities. Prisons are inspected at least once every five years, with most being inspected every two or three years. The majority of inspections are full and unannounced, assessing progress and analyzing treatment and conditions.

this problem of limited impact tend to focus on the apparent necessity for the PPO to be independent and placed on statutory footing (Steinerte 2014; Svanidze 2014). Organizational scholarship and complex systems theory, by contrast, point to the operation of adverse event investigations, moving away from critiquing individual operators (Dekker 2016) and toward examining how policy and management decisions can precipitate failure within institutional contexts (Blockley 1992; Reason 1997). Throughout this article, following organizational and complex systems scholarship, we consider the operation of self-inflicted death investigations.

Death investigations inevitably construct evidence (Scourfield et al. 2012) and, hence, cannot be reduced to "a simple fact-finding endeavour" (Scott Bray and Martin 2016, 136). Drawing on insights from organizational scholarship and complex systems theory, this article aims to help readers think critically about how the PPO constructs investigations, along with highlighting social, organizational, and institutional forces that constrain the efficacy of the PPO's death investigations and, by extension, contribute to prisoner suffering and death. We present data from semi-structured interviews with forty-four criminal justice stakeholders, including PPO staff, Prison Service staff, and coroners.[12] Our approach places the voices of some of those directly affected by human rights implementation (Prison Service staff) in dialogue with state bodies (ombudsman, coroners) and underpins it with an analysis of the gap between the ideals of prisoner death investigations "on the books" and their limitations "in action" (Gould and Barclay 2012).

In the following sections, we outline the context of imprisonment, prisoner deaths, and death investigations in England and Wales. We then mobilize organizational scholarship and complex systems theory to position prisoner deaths as systemic organizational failures. Next, we mobilize processual sociology as our theoretical framework in order to optimistically position PPO investigations as ongoing processes that include possibilities for positive change. We then introduce our data and methods. Our analysis illustrates competing notions of responsibility for prisoner deaths and differing understandings of why the efficacy of PPO investigations is constrained. As a result of organizational norms, constraints, and reporting structures, ombudsman staff have offered narrow accounts of prisoner deaths, focusing on frontline staff's lack of compliance with prison policies. By contrast, prison staff and coroners have focused on systemic hazards, or "accidents waiting to happen," such as imprisoning people with severe mental illness, illegal drugs, unsafe facilities, and inadequate staffing. We contend that this tension is itself a significant barrier to death prevention efforts given how it locks these stakeholders into an unproductive cycle of blame shifting and misunderstanding with little evidence of tangible change. We conclude by (1) mobilizing insights gathered across stakeholder groups to propose changes to PPO investigations that could improve their effectiveness and (2) exploring broader theoretic-practical implications.

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12. Findings relating to bereaved families were published elsewhere. Familial "satisfaction" with investigations very clearly required both "learning the truth" and for that knowledge to be mobilized to prevent deaths. Across these studies, all stakeholders (that is, bereaved families, PPO staff, prison staff, and coroners) agreed that the latter function was currently unfulfilled (Tomczak and Cook 2023).

IMPRISONMENT, PRISONER DEATHS, AND DEATH INVESTIGATIONS: ENGLAND AND WALES

At 141 prisoners per one hundred thousand persons, England and Wales have the highest imprisonment rate in Western Europe (Prison Reform Trust 2023, 2). In 2023, of the over eighty-five thousand total prisoners, women comprised about 4 percent of this population, which was 72 percent white, 12 percent Black or Black British, 8 percent Asian or Asian British, 5 percent mixed race, and 3 percent other ethnic groups. Minority ethnic groups are overrepresented across all stages of the criminal justice system, including police stops and searches, arrests, prosecutions, convictions, and imprisonment. This is especially true for Black individuals, who represent only 4 percent of the general population. There are also increasing religious disparities. Muslims, who make up 7 percent of the general population, have grown from representing 8 percent of the prison population to 18 percent over the last twenty years. This prison population is also aging—since 2011, the proportion of prisoners aged fifty and over has increased from 10 to 21 percent (Sturge 2023).

In 2021–22, the PPO started investigations into 287 prisoner deaths (eighty-five of which were self-inflicted) and issued 391 initial reports and 378 final investigation reports (PPO 2022, 18). In 2021–22, the PPO also made 1,125 recommendations following deaths in custody, of which 407 related to a health-care provision, 134 to emergency response, and 111 to suicide and self-harm prevention (PPO 2022, 18, 64). The Ministry of Justice's (2022) reports entitled *Safety in Custody Statistics, England and Wales*, which are available online, focus on the total number of deaths in prison custody and the proportion that were self-inflicted and from COVID-19, and they track the trends against the previous twelve months and the quarter. For instance, in 2022, the Ministry of Justice (2022) reported that there were 307 deaths, seventy of which were categorized as self-inflicted. Official sources do not publish data on mortality rates across different prison institutions or categories in England and Wales,[13] and there is limited disaggregation regarding prisoner characteristics.

PRISONER DEATHS AS ORGANIZATIONAL FAILURES

Adverse event investigators are generally confident that they can identify "the part that broke," which often equates to "the human(s) who messed up" (Dekker 2016, 6). Such narrow and linear analyses might provide satisfaction and facilitate the expression of blame, but they are inadequate to understand complex systems such as prisons. Prisons have multiple, dynamic, diverse components, ranging from the individuals involved—prisoners, staff, administrators—to the physical environment of the cells and wings, all of which interact with an array of legal, political, and social environments, such as legal judgments, sentencing policy, pandemics, and opioid drug crises.

Socio-legal scholars have long pointed to the organizational properties of legal institutions. Philip Selznick (1949, 10) argued that we must seek to understand the

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13. In England and Wales, there are four main prison categories: high security (Category A), local or training (Category B), resettlement (Category C), and open (Category D).

behaviors of criminal justice actors in the context of "the needs and structure of the organization" (see also Sykes 1958; Rothman 1980; Vaughn 1998). Malcolm Feeley (1983, 9–10) advocated replacing the premise that criminal justice institutions are "bureaucratic organizations committed to clear and well-defined purposes" with conceptualizations that understand criminal justice institutions "as arenas in which a range of competing and conflicting interests collide and vie for attention" (see also Goodman, Page, and Phelps 2017). As such, paying attention to the organizational or institutional contexts of action can reveal the "set of legitimizing scripts and logics" that penal actors "draw from in their decisions" (Boutcher 2017, 544).

Within complex systems, organizational failures, like many prisoner suicides, and, indeed, the majority of "preventable" detainee deaths, cannot be adequately explained by highlighting a single erroneous human or ineffective policy (UN Human Rights Council 2021, para. 8). In practice, failures are jointly produced by interrelated hazards that are present in the organization before the accident and by the unsafe acts of real-time operators (Reason 1997). These hazards span a range of managerial, legal, and agentic considerations that can interfere with death prevention efforts. Managerial challenges include maintaining a secure environment, providing services to meet prisoners' basic needs, and the pursuit of cost savings and/or profitability, often amidst increasing prisoner populations (see Rubin 2019). Legal challenges center on the efforts of prison staff and administrators to navigate the "terse, vague, and sometimes conflicting laws" and policies that guide their practices (Rubin 2019, 9). Additional challenges relate to the tremendous variation in how penal actors approach their work and their identification with prisons' organizational missions (Goodman, Page, and Phelps 2017). These actors hold significant discretion in how rules, laws, and policies are applied (Maynard-Moody and Musheno 2003; Reiter and Chesnut 2018). Accordingly, we must remain attentive to the ways in which formal commitments surrounding death prevention and death investigation processes are "altered, manipulated, elaborated, or ignored by the social actors who give them life" (Suchman and Edelman 1996, 907).

PROCESSUAL SOCIOLOGY

Processual sociology centers on the dynamic nature of the social world in which institutions such as prisons are continually made and remade, "instant by instant" (Abbott 2016, ix). In declaring the social world an ongoing process, this approach invites the possibility that harmful structures and relations could be unmade (Law 1992). Such optimism chafes against criminology's entrenched "miserablism," wherein its dominant focus on harm, injustice, oppression, and inequality have produced "an imaginary which is dulled to the possibilities of things being other, of resistance, of dreams, of hope" (Brown 2013, 28). Our approach also contrasts with prominent Foucauldian notions like governmental technology and "critical" conclusions that official investigations, such as those undertaken by the PPO, inevitably uphold existing power relations by burying truths and cooling politically hot issues (Scraton and Chadwick 1986; Razack 2015). Through this article, we offer scholars and community partners a means to do more than merely documenting the

harms of imprisonment, capitalizing on the power of actors to influence organizational processes (Goodman, Page, and Phelps 2017) in order to map a more optimistic way ahead (Tomczak 2022a).

A wealth of literature describes the prison as a hostile, controlling, and punitive institution of "separation, containment, constraint and moral denunciation" (Crewe and Ievins 2020, 572). Reform efforts that fail to account for the constraints and limitations of enacting change within prison contexts risk wasting time and resources and may be co-opted to extend and reinforce penal power and control (Hannah-Moffat 2000). Under a processual approach, recognizing institutional constraints and limitations does not foreclose possibilities for transformation but, rather, opens up the "black boxes" of institutional operations and agents to investigate potential points of intervention. Even whilst bound by particular contexts, we still "possess some means of struggling with that particularity" (Abbott 2016, 279). We see reconstructed PPO investigations and recommendations as potentially powerful mechanisms for disputing unsafe prison conditions and, in turn, reducing prisoner deaths and rights abuses.

METHODS

This article reports findings from a research project running from 2019 to 2021, examining how the PPO sought to improve prison safety through suicide investigations. We conducted forty-four semi-structured interviews in England and Wales with sixteen PPO staff, nineteen Prison Service staff, and nine coroners. PPO staff and coroners are rarely the subject of empirical research so their perspectives offer particularly original data (Baker 2016). Semi-structured interviews enabled participants to express complexities and generated rich data (Bryman 2012). By placing data from these diverse stakeholders in dialogue, we generated greater breadth, complexity, and richness across our analysis (Denzin and Lincoln 2000). Dialogical approaches can illuminate the largely taken-for-granted backgrounds that different groups of interlocutors assume and against which things can be said and done (Gillespie and Cornish 2010).

Sixteen PPO staff, spanning senior investigator to senior management roles, volunteered to participate in this research in response to an email invitation. The nineteen Prison Service staff in our sample came from two groups: governors/wardens of individual prisons and group safer custody leads (GSCLs). GSCLs provide regional support to prisons on reducing deaths, self-harm, and violence by identifying and sharing good practice and learning from serious incidents. Eight governors volunteered to participate following an invitation sent to prisons that had recently experienced multiple suicides. Eleven GSCLs volunteered to participate following an invitation sent to all GSCLs nationally. Nine coroners volunteered to participate following an invitation sent to all coroners in England and Wales.

We make no claim to representativeness across stakeholder groups; our sample was purposive, and participation was self-selecting, which is appropriate for this exploratory analysis in a novel area of inquiry (Bryman 2012). Ethical approval was obtained from His Majesty's Prison and Probation Service and the University of Nottingham in the United Kingdom. Interviews lasted thirty to seventy-five minutes and were all audio-recorded with participants' consent. Data have been anonymized. The same interview

guide was used across stakeholder groups. Interview topics included: (1) how the PPO seeks to effect change in prisons following a suicide; (2) whether these actions had their intended effects; and (3) if and how the PPO then adjusts its actions to better effect change.

We began by coding the interview transcripts in Microsoft Word, following grounded theory's open, axial, and selective phases (Strauss and Corbin 1998). Open codes focused on participants' explanations for prisoner suicides and their perceptions of the effectiveness of PPO death investigations. Examples included: "blame game amongst stakeholders," "implementation seen as outside the PPO's remit," and "PPO recommendations not encouraging the right kind of change." Examining relationships between open codes in the axial phase, we agreed that there were competing explanations of who and what is responsible for prisoners' deaths, why PPO investigations are currently ineffective, and what could be done to improve these outcomes. We then selectively recoded all interview transcripts through these lenses, paying particular attention to how these perspectives converged or diverged across stakeholder roles (that is, PPO staff, prison staff, coroners). Our interview data were contextualized through document analysis of PPO reports and recommendations conducted as part of a related study by the first author (see Tomczak 2022a).[14] Anonymized interview transcripts for participants who consented to data sharing, plus supporting information, are available from the UK Data Service (10.5255/UKDA-SN-855938), subject to registration.

EXPLORING THE EFFICACY OF PPO DEATH INVESTIGATIONS

Interview participants near-universally regarded death investigations as ineffective at preventing prisoner deaths. For instance, Ombudsman 8 said: "I really want to sit here and say: I think [my work] creates change, but I'm not convinced it does." Governor 6 similarly doubted that "the current PPO investigations can bring about permanent good, positive change, in the manner that is happening at the moment." Coroner 2 explained that PPO recommendations "haven't quite been followed through," suggesting that the ombudsmen are "banging their heads against a brick wall." And GSCL 7 acknowledged: "I imagine the PPO are very frustrated. Their recommendations don't stick. They're not making the impact they should." Although in agreement about the ineffectiveness of current investigations, interview participants offered a range of perspectives about why this was and what could be done to improve outcomes.

We present our findings in three sections. The first explores the narrow, compliance-oriented understanding of responsibility for deaths in prison that was advanced by PPO staff and the blame they placed on prison staff for failing to implement their recommendations. The next section highlights systemic factors within

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14. This project involved document analysis of more than one hundred publicly available PPO fatal incident investigation reports about prisoner suicides. On the PPO's website, the "fatal incident reports" page enabled the filtering of reports by category. Two filter categories were selected: "location," under which "prison" was selected and "cause," under which "self-inflicted" was selected. "Gender," "age" and "establishment" were all left on their default setting of "all." All documents were thematically coded and analyzed by the first author in Microsoft Word.

prisons that prison staff and coroners saw as responsible for producing conditions that increased the likelihood of prisoner deaths. Here, PPO investigations were constructed as ineffective because they failed to acknowledge systemic reasons for prisoner deaths. The third section describes the organizational features of the PPO that prison staff, coroners, and PPO staff themselves perceived as reducing the efficacy of investigations.

Compliance-Oriented Monitoring

Death investigations were most often constructed by PPO staff as aiming to identify individual prison staff's failure to comply with prison policies that were directly and immediately linked to a prisoner's death. This approach aligns with a "but-for" understanding of causation (Spellman and Kincannon 2001): "but-for" an individual's error or negligence, the death would not have occurred. Given this, PPO investigations predominantly focused on identifying who was to blame and making recommendations aimed at preventing individual staff errors and poor policy implementation. For instance, consider the following PPO recommendations:

> The [staff member] should write personally to the Ombudsman setting out what he is doing to satisfy himself that meaningful action is being taken to improve the response to medical emergencies. (Her Majesty's Prison Hull 2019, 3)

> The Governor should share this report with [named staff members] so they are aware of the Ombudsman's findings and should arrange for them to have refresher ACCT [Assessment, Care in Custody, and Teamwork] training. [Note that the ACCT process is used to manage prisoners at risk of suicide or self-harm]. (Her Majesty's Prison Stocken 2020, 2)

PPO staff presented a narrow, compliance-oriented construction of responsibility in which prison policies were generally seen as reasonable and deaths occurred when prison staff failed to follow them. In turn, PPO recommendations predominantly aimed to correct the errors made by individual staff that immediately preceded the death and to better align individual practice with existing policies through education, discipline, or even dismissal. When we asked PPO staff what they hoped their investigations would accomplish, most focused on changing individual practice and achieving procedural compliance:

> Well [our work] would result in a change in practice … making people behave differently and changing what people actually do … to save lives or to be fairer to prisoners. (Ombudsman 14)

> The aim of our investigations and our reports is to improve prison staff compliance with prison procedures. (Ombudsman 7)

These perspectives were reflected in the PPO's recommendations, which frequently reiterated phrases such as "the Governor should ensure that staff manage prisoners at

risk of suicide and self-harm in line with national guidelines" (Her Majesty's Prison Norwich 2021, 1) or "the Governor should ensure that all staff are aware of the local policy on responding to blocked observation panels" (Her Majesty's Prison Stocken 2020, 3). Furthermore, many PPO staff suggested that responsibility for aligning individual practice with existing policies and guidelines lay exclusively with prisons:

> We don't prescribe … we just identify when something didn't happen … it's up to the Prison Service to work out how to do it. (Ombudsman 17)

> We say there's a problem, it's up to [the prison] to identify how [they're] going to resolve it … we're … not really giving any solutions to fix it. (Ombudsman 8)

For the PPO staff we interviewed, their lack of impact was often attributed to prisons' inadequate responses to previous PPO recommendations, resulting in repeated errors and additional deaths in apparently similar circumstances. The limited success of the PPO's investigations and recommendations were typically ascribed to prison staff apathy and failure to address recommendations. As Ombudsman 5 explained, "I would say [prison staff] don't care":

> It's not a priority for them … say to a Governor, is preventing death in your prison a priority? Of course it would be. If you were to say: How much management time do you devote to looking at PPO recommendations and what you are doing to make changes? None is the honest answer. (Ombudsman 4)

> You do get some individual members of staff or establishments where the culture just breeds a kind of intransigence to change … you feel the attitude coming back of "well we have always done it like that." (Ombudsman 11)

> Nothing changes, they just … pay us … almost lip service. … They're just not learning. (Ombudsman 2)

Here, PPO staff constructed their investigations as ineffective because of straightforward prison staff choices to ignore recommendations. Additionally, PPO staff often attributed this ineffectiveness to their lack of enforcement authority, which was perceived to enable further disregard for their recommendations:

> We don't have any power to enforce anything, there are no particular penalties if we recommend do A and they might say they will do A but they don't. (Ombudsman 12)

> We make recommendations but they are *recommendations*. … We have no authority to make it happen, there are no consequences if it doesn't happen, and we have no way of following up to see whether it has happened. … One of the real reasons for our recommendations not landing and delivering

change is that we have no teeth, we have no way of making people do what we say they should be doing and what they promise us they will do. (Ombudsman 14)

By focusing their attention on procedural compliance and individual errors, PPO staff have adopted a narrow reading of their mandate, which their Terms of Reference define as "examin[ing] whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence" and "ensur[ing] ... any relevant failing is exposed ... and any lessons from the death are made clear" (PPO 2021, 11–12). The *United Nations Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions* under the 2016 Minnesota Protocol on the Investigation of Potentially Unlawful Death supplements the international UN legal standards for the prevention of unlawful death and the investigation of potentially unlawful death (UN Office of the High Commissioner for Human Rights 2016, vi).[15] Section 26 states that "the investigation should seek to identify any failure to take reasonable measures which could have had a real prospect of preventing the death. It should also seek to identify policies and systemic failures that may have contributed to a death." Rather than broadening their approach and exploring a wider spectrum of death causes, PPO staff attributed their investigations' lack of effectiveness to prison staff's disinterest in implementing recommendations that could save lives and the PPO's lack of authority to compel them to do so. In the next section, we turn to the perspectives of prison staff and coroners, who perceived systemic hazards across prisons as frustrating attempts at producing procedural compliance.

Systemic Hazards across Prisons

In contrast to the PPO's indictments of individual prison staff, prison staff and coroners attributed the ineffectiveness of death investigations to factors that the PPO ignored rather than to their willful failure to comply with policies. Prison staff and coroners believed that successful death prevention efforts required tackling systemic problems that are largely beyond the control of staff in individual prisons. Governor 3 explained: "Sometimes there's a fallback position of 'oh the Prison Service are bad' but I don't think it's necessarily as straightforward as that." Governor 5 clarified: "I don't think it always comes down to individual prisons to get things right. ... Unless we tackle the causes and some of the people we're getting through the door, this won't change." Governor 2 concurred: "Individuals get blamed, but you have to look at the wider picture." Complicating the PPO's earlier characterizations of prison staff apathy, Governor 4 explained: "We're not trying to mitigate ... not softening the blow. ... When a prisoner dies it's devastating for all ... that lack of context just makes it look like we don't care." For prison staff and coroners, more effective PPO investigations require meaningful acknowledgment of the systemic hazards present across the prison estate.

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15. Minnesota Protocol on the Investigation of Potentially Unlawful Death, 2016, Minnesota Protocol on the Investigation of Potentially Unlawful Death, 2016, https://www.ohchr.org/Documents/Publications/MinnesotaProtocol.pdf.

Some coroners and prison staff, however, did acknowledge that appeals to systemic hazards could also be used to obfuscate responsibility for errors or poor practice. As Coroner 2 explained, "the prisons just say, 'we'd like to do it, but we haven't got the resources.'" Others agreed, noting that prisons have vested interests in avoiding accountability for prisoner deaths:

> Staff fabricated things in the ACCT document. They didn't check the person, they didn't carry out their duty, very clearly … but they also tried to cover it up. (GSCL 4)

> It wasn't written down, or the CCTV has gone missing, or the logbook has gone missing … things like that happen, with various levels of credibility. (Coroner 9)

Without negating these risks, scholars warn against safeguarding reviews that emphasize policy and procedural compliance whilst lacking due regard for the contexts in which practice occurs (Firmin 2018). The subsections that follow detail the systemic hazards that prison staff and coroners relied on to explain high numbers of prisoner deaths and the ineffectiveness of the PPO's investigations: the practice of imprisoning people with severe mental illness; the prevalence of illegal drugs; old, unsafe facilities; inadequate staffing; and the concentration of these hazards in local prisons.

Imprisoning People with Severe Mental Illness

Prison staff and coroners underscored the centrality of severe prisoner mental illness in relation to deaths. Coroner 3 explained: "The inherent population has such a high percentage of people with mental health issues." Coroner 4 agreed, noting that "we know that mental health vulnerability increases the risk in prisoners' harm." Many prison staff considered prison an inappropriate setting for certain individuals suffering from severe mental illness:

> The last two deaths I've had, both those guys were hearing voices … had bizarre behaviour. Both, in my view, should never have been in custody in the first place. (Governor 2)

> There's been a couple … actually should they have been in custody? (GSCL 2)

> We're sending … too many [of the] wrong people to prison and that's contributing to all of this. (Governor 4)

These perspectives critique pervasive misperceptions that prisons are a "place of safety" for people suffering from severe mental illness—assumptions that follow the "merger of social welfare programs and crime control policies" under the carceral state (Roberts 2019a, 14).

> Magistrates ... see prison as a place of safety. Prison is not a place of safety. (Governor 4)

> Mental health services in the community are absolutely overwhelmed and often ... prisons are regarded as a place of safety. (Governor 8)

> They're meant to be put in safe places and that's not what we are. We're not a refuge, we're not ... counselling. (Governor 1)

Troubling this perspective, governors and coroners critiqued "the imposition of punishment as part of providing needed state support" (Roberts 2019b, 1701). For instance, they emphasized the "high levels of violence in many establishments" (Governor 3) and "really noisy" nature of prisons (Governor 2) as being particularly problematic for ill people. As Governor 4 explained, "prison is a chaotic environment ... if you're unwell, struggling ... it's just a hideous place." Others elaborated on the connection between mental illness, self-harm, and the prison environment: "[Prisons] are awful places ... people are at their lowest ... if anyone is predisposed to ... self-harm or any mental health issues, it's going to come out" (Coroner 8). These observations are validated by the Criminal Justice Joint Inspection (2021, 10), which looked into the criminal justice journeys for individuals with mental health needs in England and Wales, highlighting the "totally unacceptable" practice that "prisons continue to be used as a place of safety."

Moreover, uniformed prison staff have a "lack of training to even know how to start to deal with" the severity of mental illness that is too regularly seen amongst prisoners (Governor 7), whilst specialist prison mental health services are often only available during office hours (Wright, Jordan, and Kane 2014). Governor 2 explained: "I've got a guy now in the constant watch cell, every time we undo the door, he's attacking staff, he's trying to kill himself." Extending this picture, the National Audit Office (2017, paras. 1–2) highlighted that the UK government "does not know how many people in prison have a mental illness, how much it is spending on mental health in prisons or whether it is achieving its objectives."

Prison staff argued that, rather than engaging with this systemic issue, the PPO reduced deaths to individual staff errors and procedural issues. For instance, GSCL 2 suggested that the PPO frequently overlooked the difficulties of transferring severely mentally ill prisoners to secure psychiatric treatment, whilst focusing on the emergency code radioed in critical incidents:

> I had a prisoner who I was really, really fearful would take their life. ... The establishment had been trying tirelessly to get them moved to where they needed to be, which was not in prison ... they did so much work, they kept them alive. ... If they take their life none of that will be taken into consideration. ... It's a horrible thing to be involved in and then you ... get told you didn't call a Code Blue.

The PPO regularly criticized staff for not using the correct emergency response code—Code Blue is for breathing issues or collapses; Code Red is for blood or

burns—even when it would not have prevented death or did not create a delay in ambulance attendance.[16] Governor 3 explained that the PPO's "obsession with . . . repeat recommendations around Code Red/Code Blues" caused prison staff "frustration." Similarly, Governor 4 suggested that the PPO unfairly critiqued prison staff actions in high pressure, crisis situations: "The PPO . . . are not factoring in . . . the human element. . . . I defy anybody to say: 'This is how I would react if I found a prisoner hanging'. . . . While we're sat here: 'Well of course I would ring and call Code Blue or Code Red because I know all that' but when you see a body for the first time, I defy anybody to be able to follow it to the letter."

Whilst it is highly desirable that ambulances are called and health-care staff are summoned promptly with appropriate equipment, prison staff argued that the PPO's repetition of recommendations about emergency codes focused entirely on the sharpest end of the death prevention spectrum. For prison staff, the PPO were seeking to influence one of the most pressured areas of frontline practice, whilst overlooking the systemic hazards of imprisoning people with severe mental illness (Criminal Justice Joint Inspection 2021) and long delays with transfers to secure hospital that increase pressures within prison environments (Sharpe et al. 2016; Independent Monitoring Boards 2022, 9) and, as a result, the likelihood of prisoner deaths (Reason 1997).

Prison staff suggested that PPO investigations could seek to expand awareness of inadequate mental health services to meet prisoner needs, which they believed would make significant improvements to regime pressures. Governor 6 stated: "[The PPO could] help us in terms of looking at services for mental health . . . looking at have we got enough . . . help us influence services." For Governor 2, obtaining more mental health services was the potential "blue-sky" outcome of PPO investigations: "If it was an ideal world that's what [the PPO] have got to do . . . come in and say right . . . we will provide more mental health services." Nevertheless, it is important to acknowledge the limits of such incremental reforms to mental health care within punitive institutions defined by their commitments to deprivation, risk management, and responsibilization (Augustine et al. 2021).

The Prevalence of Illegal Drugs

When asked about the factors contributing to deaths in prisons, prison staff and coroners were quick to mention the prevalence of illegal drugs in prisons:

> Until we stop the insidious entry of Spice in prisons, we will still get the sad deaths. (Coroner 3)

> We've got a vulnerable population . . . mental health and behaviour and substance misuse issues. (Governor 8)

> You really need to watch people who are on Spice because there's a batch going around which makes people quite violent and when they come down from it, it makes them kill themselves. (Coroner 9)

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16. Prison Service Instruction 03/2013: Medical Emergency Response Codes, February 1, 2013.

Beyond the risks of overdosing, illegal drugs exacerbate problems with bullying and violence. Drug use in prisons can lead to significant debts being accrued with dealers, potentially followed by assaults and threats if payment is not secured (Ireland 2000). The inspectorate report from Her Majesty's Inspectorate of Prisons (2018, 5) in Nottingham explained: "The problem of drugs … as always, was inextricably linked to violence. … Not surprisingly, in a prison which could be defined by the prevalence of drugs and violence, the level of suicide and self-harm was both tragic and appalling." Moreover, in its annual report, Her Majesty's Inspectorate of Prisons (2019, 7) characterized prisons overall as "plagued by drugs, violence, [and] appalling living conditions."

Prison staff and coroners felt the PPO unfairly singled out individual prisons for not effectively managing drug problems that were endemic across the prison estate (Ralphs et al. 2017): "Spice and the terrible problems with Spice. … It's rife in every prison across the land and because they've got a PPO report … that says 'you failed to deal with it properly', they can feel, 'oh god'" (Coroner 9). Similar to their suggestions regarding mental illness, prison staff and coroners felt that PPO investigations could be more effective by seeking to influence drug policies on a broader scale. As Coroner 1 explained, "it would be helpful if the PPO could say right: 'look at your drugs policy.'" GSCL 9 agreed: "I think [changes] would have to be set at a national level. … I mean the logical progression would be to make the recommendation to the MP [member of parliament] of the area or the Prime Minister. … You could go all the way up." Whilst prison staff frequently described illegal drugs in prisons as having system-wide impacts, neither prison staff nor, peculiarly, PPO reports mentioned the related systemic issue of prison staff bringing drugs into prisons (Norman 2023).

Old, Unsafe Facilities

Old prison buildings and a lack of investment in facilities were characterized across stakeholder groups as contributing to prisoner deaths. Coroner 2 noted that "facilities are poor," and Governor 5 explained that their prison was "a very challenging environment," being "[over one hundred] years old and showing every sign of that." GSCL 5 put these old facilities and a lack of investment in prison buildings into focus, saying that "a lot of the buildings are very old … quite decrepit, not fit for purpose." These environments were frequently suggested to play a direct role in prisoner deaths: "I've got a Victorian local prison … we've got guys doubled up in cells with … loads of ligature points, that's not safe" (Governor 2). These findings enhance the limited literature on relationships between prison architecture and prisoner suicides, which has suggested that older facilities—which often have poor lines of sight and limited spaces for interactions between prisoners and prison staff—are associated with a greater number of suicide attempts than newer prisons, although self-inflicted deaths also occur in newer facilities (Beijersbergen et al. 2016).

Old, unsafe prison facilities are largely beyond the control of governors, and they could induce a sense of helplessness amongst staff, as encapsulated by Governor 8, who described the "lack of investment" in their "old Victorian Prison" and then lamented: "What do you do? The Courts keep sending, they still need to put

people ... somewhere." In 2020, the National Audit Office (2020) also highlighted that prisoners are being held in unsafe and overcrowded conditions without access to requisite services. Once again critiquing the PPO's focus on emergency codes, Governor 7 stressed the daily difficulties of keeping prisoners alive within unsafe facilities and the lack of resources to address these environmental challenges:

> Rather than: "The Governor should send out a notice to staff reminding them that they should use Code Red and Code Blue appropriately". What I actually need is the ... anti-ligature ... to keep them alive for thirty years. ... I don't think I've ever felt supported by the Ombudsman. ... There are things that I am crying out for ... they have another voice that they can use ... please can you raise this on our behalf?

To mitigate these systemic hazards, governors and coroners advocated for greater investment in safer cells. In controlled environments such as prisons and hospitals, access to the means of hanging (the most common method of suicide worldwide) can be restricted through the use of safer cells that are free from ligature points, that use ligature-free bedding and clothes, and that have collapsible ligature points such as shower rails (Gunnell et al. 2005). Of course, removing the means cannot entirely tackle suicidal ideation, but it can prevent deaths acutely. In particular, governors asked for the PPO's help in encouraging the government to increase the availability of safer cells. Governor 2 noted that prisons need "facilities to care for people" and proposed that, in an ideal world, the PPO would "come in and say: 'Right we will give you single cells, we will give you safe furniture.'" Governor 7 agreed, suggesting a shift in the PPO's recommendations from "[prison staff] need to follow the rules" to "the government whittling up monies for safer cells."

Inadequate Staffing

Prison suicide rates more than doubled following the government's 2012 benchmarking policy, which drastically reduced the number of prison staff, whilst maintaining prisoner numbers, in an effort to reduce the cost of public sector prisons to align with the private sector (Tomczak 2018, 2022a). As Governor 2 explained, "the impact of benchmarking has been huge, staff want to do a good job but can't." Coroner 2 agreed: "Prisons haven't got the staffing." Other governors described the scale of this problem (see also Council of Europe 2022):

> I [had] ninety-one officers ... I should've had 160–170. (Governor 6)

> The Prison Service is creaking under pressure. ... I've got wings of ninety men, with four Officers. (Governor 7)

Prison staff felt that the PPO's criticism of their response times to cell bells—a mechanism prisoners can use to alert prison staff of an emergency—failed to account for staffing limitations. Governor 4 described a situation in which a single staff member had

to respond to "three thousand emergency cell bells [in one] day." GSCL 9 expanded: "The PPO says: 'Cell bells aren't getting answered within the four-minute time'. . . . Look at the twenty-four-hour period and you'll find . . . one wing . . . something like twenty-five hundred cell bell activations. . . . Just say: 'The staff are doing their best, but they're snowed under.'" Governor 2 similarly perceived some of the PPO's recommendations as nonsensical given staffing and service provision inadequacies: "In a Cat[egory] C Prison [resettlement prison for prisoners who are unlikely to attempt escape] at five [pm], there's no Healthcare. . . . You can't say every prisoner must be seen by a member of Healthcare before being put on a constant watch if there's no Healthcare in the Prison."

Prison staff frequently described the PPO reports as holding them individually responsible for a level of service that was impossible amidst systemic staffing cuts and shortages. Regarding recommendations about compliance with the ACCT process, a judicial review granted to two bereaved families in November 2016 led the government to commission an independent professional report, which highlighted that ACCT "was designed at a time when the number of staff in prisons was significantly higher . . . and . . . the prison population was significantly lower" (Shaw 2017, 36). Stephen Shaw's (2017, 11) report also pointed out that Prison Service Instruction 64/2011 "[l]ists no fewer than twenty-six risk factors for suicide and a non-exhaustive list of eleven possible triggers. There can be few if any prisoners to whom none of these factors or triggers applies. Indeed, the mental health criterion would include over half the entire prison population" (Ministry of Justice 2013, 18, 20).

Although the PPO does not mention staffing issues in its reports, Ombudsman 9 acknowledged that staffing levels made governors' jobs "horrendous." Crucially, however, Ombudsman 9 immediately dismissed this systemic concern as "not our problem," reinforcing the PPO's narrow and compliance-oriented approach to responsibility. Prison staff held that inadequate staffing increased the risk of prisoner deaths, whilst compounding problems such as high levels of staff stress and staff "churn" (movement between positions) resulted in further instability for prisoners and staff:

> I've seen real churn in Heads of Safer Custody . . . We had four, all went off with stress. . . . Heads of Safer Custody are consistently in Coroner's Court, all the time. (Governor 2)

> There's far too much churn amongst the governor grades that manage Heads of Safety and very often they'll be put in there with no experience and no training. (GSCL 4)

Short staffing contributes to job stress, burnout, and ultimately staff turnover (Finney et al. 2013). As a result of high levels of staff turnover, prisons are continually engaged in training new or promoted staff that detracts from advanced staff training, professional development, and gaining robust experience within particular positions, all of which have significant implications for the quality of practice (Lambert and Paoline 2010). In response, prison staff have suggested that the PPO could help by challenging central decision makers regarding staffing levels relative to the prisoner population. With appropriate staffing, prison staff believed that prison policies and the PPO's

recommendations could actually be followed. Whilst this is an understandable perspective in the contexts described above, even with higher staffing levels, multiple systemic hazards would remain significant obstacles to meeting the PPO's expectations, and, inherently, imprisonment is a stressor that can trigger suicidal behavior (Larney and Farrell 2017).

Concentration of Hazards in Local Prisons

Governors suggested that local prisons, used for detainees pre-trial, the newly convicted, and those serving short sentences (similar to jails in the US context), saw a concentration of systemic hazards and suicide risks. Governor 5 noted that "locals are much more challenging" than other types of prisons because prisoners coming directly from courts were often "chaotic individuals" requiring significant work to simply "stabilize." Governor 4 elaborated that "self-inflicted deaths occur most often in the local prison estate," noting that "the same prisons are always in the press … they're all local prisons." They added: "By the time you get a prisoner sentenced and to a training prison [for sentenced long-term and high security prisoners] … you've stabilized their mental health, the drugs. You know that the family is going to maintain contact. The person knows what sentence they've got. … Local prisons are all about the unknown."

Local prisons also struggled because of their large populations and high number of prisoner receptions. Governor 8 noted that at one point their local facility contained 1,350 men and received sixty to seventy new prisoners every day. Within these large local prisons, a high proportion of prisoners were also identified as being at risk of suicide or self-harm and managed through the ACCT process. Governors expressed frustration that the PPO failed to recognize the degree of challenges that local prison staff faced. Governor 2 critiqued the "generic view" taken by the PPO, which did not account for variations across different categories of prisons and their populations: "What you can probably do in a training prison with three or four ACCTs is totally different to what you can do in a local prison with thirty ACCTs." Governors asked for the PPO's help, for example, by encouraging the Prison Service to "look at the role of the local prisons" and advocate that they receive more "mental health, substance abuse and psychological services" (Governor 4). Of course, reducing the prison population—in particular, the recent record numbers of remand/pretrial detention prisoners—is also required to support the functioning of local prisons (Ministry of Justice 2023).

Summary

This section has highlighted the systemic hazards that prison staff and coroners saw as being responsible for increasing pressures within the prison environment and increasing the risk of suicides. They argued that PPO investigations would be more effective if they focused on raising systemic hazards with central government decision makers who had the capacity to change prison policies, resource allocation, and sentencing policies. In the next section, we turn to the organizational features of the PPO that were perceived to further reduce the impact of their investigations.

Organizational Features of the PPO

Prison staff, coroners, and PPO staff all perceived organizational factors within the PPO to be frustrating their death prevention efforts. These factors included the focus and culture of the PPO; the relationships with the Prison Service; and the form and content of the PPO's reports and recommendations.

Focus and Culture of the PPO

One prominent critique by prison staff and coroners was the PPO's casework focus—investigators prioritized the facts and events pertaining to individual deaths at the expense of a broader view that identifies patterns and contributing factors. As Coroner 8 explained, PPO staff are "looking at a particular death in a particular prison in a particular set of circumstances" without embracing considerations about "what is happening across the whole prison estate." Others agreed:

> It was very difficult to convince the PPO that it would be better ... for safety ... to look at some of the overarching issues ... because they're all linked. (Coroner 5)

> My view on the PPO is they look at stuff in isolation ... what they need to understand is the context. (Governor 4)

> The PPO is very short-sighted. (GSCL 12)

Many suggested that the PPO's casework focus was limiting and underscored the importance of a broader approach:

> We need to be looking at the longitudinal history, rather than ... this particular case. ... Is this a theme at this particular establishment? Is this a theme nationally? (Coroner 4)

> No death is ever for one reason. Normally it's a collective of reasons and understanding that ... is really key to outcomes. (GSCL 13)

In spite of their current casework focus, some participants felt that the national PPO was well positioned to undertake this strategic, proactive work across the prison estate, holding more systemic insights than the other two locally based investigation bodies (police and coroners), which were discussed in the introduction:

> The PPO can provide that level of clarity for the officials in the Probation Service, Prison Service, MoJ [Ministry of Justice]. ... I think they're in a much better position than say Police Forces or Coroner Services or anybody else that's conducting any other kind of inquiry into what's happening across the whole prison estate. (Coroner 8)

> [The PPO] are very well placed to identify the problem and if they can't escalate it to the right place, you're missing an opportunity, aren't you? (Coroner 5)

PPO staff largely accepted the critique that "there is a gap seeing the bigger picture" and attributed this to a range of "organizational design issues" (Ombudsman 7): "We're so busy doing singular cases … we haven't had the capacity to draw attention to the significance of what all these individual cases are telling us" (Ombudsman 8). One of the major reasons offered for this lack of broader thinking was ineffective communication between PPO staff: "You often don't see your colleagues for a while, so we haven't really got the individual relationships. … That's partly due to the way we work in singleton posts … we're not really part of a team" (Ombudsman 11).

Limited connections amongst colleagues were suggested to constrain opportunities to identify patterns in their individual cases and "spot trends before they happen" (Ombudsman 15): "For senior managers [in the PPO] … they might not have realized … how big an issue was because they might've only heard it from one of their investigators. But when you've got people on other teams saying 'well actually I've had the same thing', then it … builds up a better picture of what organizationally we should be focusing on" (Ombudsman 10). Although most PPO staff saw their casework focus as a shortcoming—and as potentially related to their investigations' ineffectiveness—others disagreed. Some participants explained why the PPO leadership avoided recommendations that focused on systemic problems: "If you're talking about things that can only be achieved if there is X number of staff to run the show, then you might have to say well, 'maybe we can't say that because there was only two people on duty and that's the number that they were allowed to have', so we can't then go 'well you need more staff to look after this'" (Ombudsman 4).

The PPO's management team apparently encouraged staff to provide pragmatic recommendations that were grounded in the realities of existing prison resources. As Ombudsman 4 explained above, the PPO's management perceived it to be irresponsible to offer recommendations that could not be implemented without additional resource investments. Ombudsman 13 agreed, noting that "prisons are, I'm sure, always going to be struggling for money, struggling for resources" (although this view obscures the historic staff reductions from 2012 and the impacts of fiscal austerity since 2010). This is a crucial indicator of the stakeholders' diverging constructions regarding the reasons for the PPO's lack of efficacy: prison staffs' major frustration with the PPO was its lack of engagement with systemic hazards—most of which were believed to require greater investments in prisons, be that additional staffing, programming, or infrastructure.

PPO staff also discussed the PPO leadership's caution around extrapolation—for example, about the role of systemic hazards (particularly staffing levels) in prisoner deaths:

> We were never really encouraged to be weighing in [on] the debate about staffing levels or regime acceptability. It was always like: 'No, because this is just one person's death, and we can't extrapolate from that'. (Ombudsman 15)

We're never allowed to use [staffing levels] in our reports. ... We can never excuse things by saying 'they didn't do this, but they're really short staffed'. ... So whilst staff might be saying ... 'there's just not the staff on the wing, we can't be expected to do this' or 'I didn't check him because actually there was only two of us, there was lots of cell bells going'. ... That might be true, it might not be true, who knows. ... It's really hard to work out how accurate the resourcing issue is in terms of this particular prisoner's death. ... I've always got the sense we're not allowed to use that ... because you could excuse anything that happens on that basis and ... we would never let them off the hook. (Ombudsman 13)

Relationships between the Prison Service and the PPO

Participants with different roles perceived effective death investigations to be the outcome of successful collaborations across stakeholder groups:

Good inquests are a combination of everything, a good PPO investigation, the Coroner doing [their] job, the family being ... amply represented ... the staff being appropriately asked questions ... if it was more of a team effort and you put all the pieces of the jigsaw together, we would get a better outcome. (Coroner 7)

We need to work together to stop suicides in prison. That's about it ... in a nutshell. (GSCL 10)

Yet participants across roles highlighted a variety of issues with the requisite stakeholder collaborations. A major challenge mentioned by both prison and PPO staff was the lack of, or inefficient, communication between stakeholders. Notably, participants described the relationship between the Prison Service and the PPO as poor and unproductive. Prison staff frequently expressed how the PPO's communication style intensified the stress of their work and made it more difficult to correct harmful practices. When we asked Governor 1 about the ways in which the PPO could improve, they stated simply: "Better communication."

Multiple prison governors noted the long timelines to produce the PPO's reports and requested earlier, informal communication from the PPO about their findings. Some governors suggested that the PPO could implement the verbal debriefs provided by His Majesty's Inspectorate of Prisons or share a draft of the emerging findings. Governor 8 explained that earlier, informal communication would offer prisons "an opportunity to address stuff [they] haven't spotted ... rather than waiting for the final report." Some prison staff linked earlier communication with more effective death prevention efforts:

It'd give you the opportunity to act on things that you may not have been aware of to avoid further issues. The last thing anyone wants is another death. (Governor 1)

> PPO reports take so long to come in … they kind of lose their bite. If
> something's not right, I need to know about it now. I don't need to know
> about it in eight months because in that time I could've had another three,
> four, five deaths. (GSCL 12)

Other prison staff agreed, noting that for the PPO's recommendations "to be useful"
they must be communicated to prison staff "as close to the event as you can" (Governor
8) or risk "losing momentum by the time the report comes back" (GSCL 4).

Participants across roles also spoke about the impacts of what were frequently poor
relationships between the PPO and the Prison Service more broadly:

> There seems to be an "us" and "them" thing about the Prison Service and
> PPO. (GSCL 7)

> [There is] tension between the PPO and prisons. (Ombudsman 13)

> You see in all PPO Reports, 'I wrote to your staff to invite them to provide me
> with information, nobody responded', well that probably tells you about their
> perception of the PPO. (GSCL 11)

Others noted that the tone of the PPO's engagement with prison staff could further
impair this relationship:

> [PPO investigations] cause a bit of conflict … [PPO staff] would be quite
> hostile … hyper-critical … they could be quite abrupt and when you've got
> [prison] staff that've been through a death, they can be quite shaken. … If
> someone comes in quite hostile then they don't get the best out of it.
> (Governor 2)

> You don't need someone to come in and bang the drum and say "you're all a
> bit shit, start listening to our recommendations" … which is sometimes how
> it feels. (Governor 5)

Some PPO staff acknowledged that their relationships with prison staff were made worse
by the negative focus of their reports, which predominantly highlight failings and poor
practice: "We see worst case scenarios when the person has died. We don't know about
all those lives they save … that's probably really hard from a prison perspective,
actually when I think about it" (Ombudsman 13). PPO staff, coroners, and prison staff
agreed that the negative tone of the PPO's reports, combined with their narrow focus,
often resulted in prison staff becoming defensive, disengaging from their recommen-
dations, and seeking to distance themselves from blame rather than engaging with the
substance of the reports (Tomczak and McAllister 2021):

> If [prison staff] have read a critical PPO Report, they're extremely defensive
> and will close up and think, "I'm being attacked" … I hear from prison staff,
> in relation to PPO recommendations, that they feel singled out for something

that's obviously a national problem. ... If [recommendations] went nationally, not only would they have greater reach but it would mean that prisons didn't feel singled out and get defensive. (Coroner 9)

If all the prison see is us criticizing them all the time, they're not going to give sufficient weight to our recommendations. If they saw the times they got it right, they might take it more seriously when we tell them they've got it wrong. (Ombudsman 6)

Supporting Ombudsman 6's suspicions, GSCL 4 explained that the lack of acknowledgment regarding good practice "water[ed] down" the impact of the PPO's recommendations: "It feels like a kick in the teeth ... when actually the process you've done has been really good ... it almost waters down the rest because you think if they're going to pick holes in that when actually we did a good job in the rest of it, it can sometimes feel like they're just picking holes for the sake of it." GSCL 9 agreed, noting that the PPO's recommendations would likely be "tak[en] a little bit more seriously" if they were "more balanced" in their feedback to prison staff.

While recognizing that the frequently negative focus of their reports could antagonize and alienate prison staff, some PPO staff expressed hesitancy about offering praise:

Our reports are very much focused on the failings rather than the successes, but a point that's been made to me, which I think is a valid point, is that you also have to think about the family reading that report who have lost a loved one. Is it appropriate to praise the prison about 'oh they did lots of wonderful work with this person' when ultimately they died? It's quite a delicate balance. (Ombudsman 7)

Ombudsman 7's point about their reports' audience is an important one. The primary audiences of PPO reports are the prisons being investigated, the bereaved families, and the coroner. PPO staff consistently noted how the perceived requirements of diverse audiences, especially bereaved families, influenced how they approached their work.

Form and Content of the PPO's Recommendations

While prison staff offered numerous suggestions about how the form and content of the PPO's recommendations could be modified for greater effectiveness, many PPO staff readily admitted that they had never given this any consideration. Ombudsman 14 explained: "I never really thought about this until we had this conversation." Others expressed a similar lack of reflection:

I haven't really considered it to be honest. ... The way the reports are structured. ... I don't really have any opinion on it. I think that's partly because I got used to doing it the way it is ... rather than thinking about could I do it better? (Ombudsman 11)

> I've not given it too much thought, I think the format is fine … a couple of years ago, there was a push "oh let's make [the recommendations] smarter", but that never really took off. (Ombudsman 7)

> I don't know if there's any problem [with] the recommendations. … We're cutting and pasting … so more could probably be done, to be honest, to reflect on practice and things that we're coming across. (Ombudsman 13)

This notion of "cutting and pasting" was pervasive amongst PPO staff. As Ombudsman 8 explained, "when it comes to actually writing findings and recommendations, I'm a bit of a cutter and paster, I'm not going to lie." These practices largely stemmed from the creation of a recommendations database that PPO staff were encouraged to use by the PPO's management: "I think people used to make whatever [recommendations] they saw fit for that case and then it moved to a model whereby we were following a joint recommendations database and using the recommendations from there" (Ombudsman 3). One of the primary reasons advanced for using these generic recommendations was consistency:

> A lot of our reports are repeated, as you probably know, but that was almost encouraged here. … I mean we have a recommendations database … to ensure you're being consistent with previous recommendations. (Ombudsman 8)

> If you're making a similar recommendation and every single report has got slightly different wording. … I don't think that looks particularly good on us … that's why we try to use the standard wording. (Ombudsman 7)

Whilst consistency across reports may support outcomes such as the identification of systemic hazards, it also appears that the recommendations database may have inadvertently discouraged PPO staff from reflecting upon the efficacy of their recommendations. This was more concerning given that PPO staff often noted that they were unaware of where the recommendations database, or the evidence base informing its principles, came from (see also Tomczak and McAllister 2021): "It's been around for probably about six or seven years now. … I think probably someone just decided it was a good idea one day and let the team carry on with it" (Ombudsman 8).

One of the unintended benefits of our interviews was that some PPO staff began to reflect on the form and content of their recommendations for the first time. For instance, two PPO staff began to question whether their focus on consistency had gone too far during our interviews:

> I wonder whether we can go too far to the other extreme where we're not making [recommendations] personalised enough? (Ombudsman 3)

> There's a driver to be consistent in our recommendations … on the one hand to try and make sure they're easily understood, but then equally some are

just so generic that it leads to generic responses that don't make any positive changes. (Ombudsman 10)

These nascent perspectives mapped onto prison staff concerns about the utility of the PPO's recommendations for addressing systemic hazards. Reflecting the concerns about generic responses, Governor 5 admitted that they were often more focused on formulating a response to the PPO's recommendations—in the form of an action plan—than on translating those recommendations into meaningful change: "I think we've become focused on delivering the Action Plan rather than shifting the culture. ... I worry that sometimes, in the [current] system, the response is more bureaucratic than a cultural shift" (Governor 5). Other prison staff agreed, questioning the impact of their action plans:

> There's a danger that it becomes about the process of satisfying the PPO, rather than about looking to right the things that we've failed on and [that] contributed to a fatal incident. (GSCL 8)

> It becomes a bit of a tick-box exercise and you can lose some of the nuance behind why we're doing it ... we're doing it because we're told we have to. (GSCL 12)

Action plans frequently used a notice to staff as the prison's official response to failings identified by the PPO, despite widespread skepticism that this would result in meaningful change. As Governor 7 declared, "I have very little confidence that a notice to staff will do the job." GSCL 8 agreed, explaining that this generic response ultimately trapped all parties in an unproductive cycle:

> I'm fed up [with] that as a stock answer, "we'll publish a notice to staff". Everybody's already been trained and notices to staff have already been published, so the root of evil lies somewhere else ... the way the Action Plans are set out and are worded lead us to keep providing those stock answers. ... I bet they're sick of reading them as much as we're sick of writing them.

DISCUSSION AND CONCLUSION

In this article, using England and Wales as a case study, we have assembled some of the first evidence illustrating how investigators and adjacent actors construct prisoner deaths and have set out the implications of their constructions. UK detention monitoring is often considered to set the standard for oversight entities around the world, yet our research revealed consensus amongst PPO staff, coroners, and prison staff that death investigations have been largely ineffective at changing the harmful practices and contexts associated with high numbers of prisoner deaths. Supporting these perspectives is the quantitative evidence that self-inflicted prisoner deaths in England and Wales have risen substantially over the last decade (Tomczak 2018, 2022a). Our

research explored participants' differing understandings of why the PPO's investigations have been largely ineffective, considering the organizational constraints on the form and content of the PPO's reports and what could be done to improve outcomes.

PPO staff largely advanced a narrow and compliance-oriented understanding of responsibility, holding prisons and prison staff responsible for the procedural issues and individual errors that immediately preceded prisoners' deaths. Prison policies were generally seen as reasonable, and deaths were believed to occur when prison staff failed to follow them. The PPO envisioned this approach to responsibility as guarding against the potential for prisons and prison staff to make excuses for, to cover up, or, otherwise, to avoid accountability for negligent practices and fatal errors. PPO staff suggested that their investigations were ineffective because prison staff failed to take their recommendations seriously and made no meaningful attempts to change their harmful practices. For PPO staff, improving the impact of their investigations would require that they received greater authority to compel prison staff to be compliant with their recommendations and/or hand down consequences for noncompliance.

Reflecting a different perspective, prison staff and coroners argued that prisoner deaths were less the result of individual errors or procedural compliance issues and more to do with systemic hazards across the prison estate: imprisoning people with severe mental illness; the prevalence of illegal drugs; old, unsafe facilities; inadequate staffing; and the concentration of these hazards in local prisons. Prison staff and coroners viewed the PPO's investigations as ineffective because their recommendations do not engage with the underlying contexts in which prisoner deaths occur. Prison staff and coroners argued that the PPO's narrow and compliance-oriented understanding of responsibility concentrated attention on frontline actors with limited control of their work environments, whilst leaving other actors unexamined and thus unaccountable, including central government officials with the substantive decision-making authority and resources to influence prison conditions more broadly. To improve the impact of the PPO's investigations, prison staff and coroners suggested that investigations should focus on the systemic hazards that were increasing the risk of prisoner deaths—both to appreciate the broader contexts in which staff make fatal errors and to raise these systemic issues with the central government.

Whilst the systemic hazards identified by prison staff and coroners are consistent with those identified in scholarly literature and reports by prison oversight bodies, it is notable that not one of our forty-four interview participants recognized that England and Wales have the highest incarceration rate in Western Europe (Prison Reform Trust 2023). This matters because being imprisoned is a stressor that can induce psychological disturbance amongst those with no history (Liebling 2007, 433). Moreover, actualizing the suggestions of prison staff and coroners would channel additional resources (for example, staff, programming, infrastructure) into inherently problematic prison institutions.

Our aim in this article was to understand how differing explanations of prisoner deaths are organizationally produced and collectively contribute to the overall ineffectiveness of the PPO's investigations. Our study's inclusion of multiple stakeholders—PPO staff, coroners, governors, GSCLs—allowed us to continually interrogate and complicate their dueling assumptions and constructions of responsibility in light of their organizational milieu. Without this dialogical approach, one might
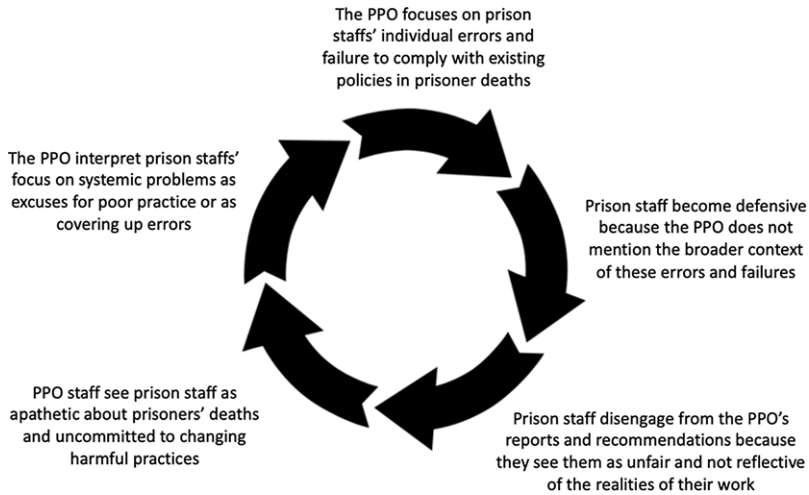
The PPO focuses on prison staffs' individual errors and failure to comply with existing policies in prisoner deaths

The PPO interpret prison staffs' focus on systemic problems as excuses for poor practice or as covering up errors

Prison staff become defensive because the PPO does not mention the broader context of these errors and failures

PPO staff see prison staff as apathetic about prisoners' deaths and uncommitted to changing harmful practices

Prison staff disengage from the PPO's reports and recommendations because they see them as unfair and not reflective of the realities of their work

FIGURE 1.
An unproductive cycle.

uncritically accept one group's explanation that the PPO's investigations are ineffective merely because they ignore the real causes of deaths in custody or because prison staff do not care about implementing the PPO's recommendations. By drawing on insights from organizational scholarship and complex systems theory, we uncovered a broader range of organizational structures, constraints, and reporting requirements contributing to these differing constructions of prisoner deaths and death investigations as well as their effects. As an example, Figure 1 demonstrates how stakeholders' differing constructions of responsibility locked prison staff and the PPO in an unproductive cycle of blame shifting and misunderstanding that further deteriorated their working relationship.

Rather than working together to make prisons safer—a goal that was shared across PPO staff, coroners, and prison staff (see Tomczak and McAllister 2021)—these actors were locked in an unproductive cycle over who was responsible for prisoners' deaths, devoting tremendous energy to blame shifting, with little tangible change. It is our contention that this tension over responsibility is itself a significant barrier to death prevention efforts. As the Canadian Federal Prison Ombudsman advocates, the dual purposes of death investigations—determining the circumstances of one death and assessing the broader environmental factors that heighten the risk of deaths overall—should be considered complementary: "Through investigating individual cases, ombudsmen may highlight weaknesses. ... The resulting improvements in the system provide a generalized benefit. These two roles do not conflict, nor should they be separated. ... Feedback could ... lead to improvements when investigations reveal systemic problems or failures" (Sapers and Zinger 2009, 1515).

Inspired by this integrated vision, we propose an expanded view of the factors relevant to the PPO's investigations. Drawing on the legal concept of proximate causes (Clarke 1981), we recommend placing the individual errors that the PPO currently identify within their broader organizational contexts of risk, disrupting the unproductive cycle of blame shifting observed in Figure 1. The PPO should shift its

current focus on who is responsible for a particular prisoner's death to also incorporate considerations of why certain fatal errors continue to occur and what policies or procedures within prisons and/or the PPO—and, indeed, police, courts, and broader society—must be revised in order to prevent them in the future.

Consider the following example to illustrate the shape of this proposed shift. The PPO very regularly assigns individual responsibility for failures related to cell checks, offering recommendations such as prison staff should "carry out observations at the agreed frequency" (Her Majesty's Prison Norwich 2021, 1). However, these recommendations miss the context of these fatal errors, as do prisons' action plan responses that prioritize "reminding" or "refreshing" staff on the importance of compliance with policies about cell checks. A more expansive understanding of responsibility and causation would also ask questions such as: why are cell checks so often not conducted at the required frequency; why are prison staff taking so long to respond to call bells; why are so many prisoners classified as "mentally ill"; what policies could be changed to alter these conditions; what recommendations could the PPO make to assist in this process? Exploring these types of questions would not only provide a fuller, and more accurate, understanding of individual deaths, but they would also generate insights that could be raised across the prison estate and potentially prevent deaths.

As a result, we see an expanded role for the PPO in raising questions that highlight a broader range of problems and risks within and beyond the prison estate. If political sensibilities inhibit the PPO from identifying systemic hazards, the PPO should clarify what they do not do in their Terms of Reference. It would be useful and fairer for all stakeholders, including coroners and bereaved families (Tomczak and Cook 2023), to have a transparent understanding of what matters the PPO can and cannot consider. In proposing that prisoner deaths occur at the intersection of systemic hazards, organizational contexts, and individual errors (Reason 1997), we do not wish to make a blanket declaration about the relative influence of each of these factors. The salience of each of these factors will vary between individual cases. Instead, we envision our analysis as a sensitizing tool (Blumer 1954) that may guide PPO investigations in asking different sets of questions that could illuminate a broader range of organizational and institutional factors implicated in prisoner deaths. Our focus on prisoner deaths as occurring at the intersection of systemic, organizational, and individual factors, and exploring the reasons for differing constructions of these failures across stakeholder groups, may also be helpful in explaining and perhaps contesting other enduring carceral failures, such as high recidivism rates, high uses of force, and inadequate health care.

Our research also revealed that changes within the PPO could make its investigations more effective. For instance, we see benefits in consistent earlier and informal communication between PPO investigators, prisons, and central government decision makers about emerging findings (Tomczak and McAllister 2021). This type of communication could mitigate the delays between a fatal incident and the PPO's draft reports being delivered, potentially allowing prisons to correct errors more rapidly and exerting pressure on central government decision makers to tackle the prison conditions that produce sustained high numbers of prisoner suicides and deaths. We also see a need for greater reflection on the form and content of the PPO's recommendations,

particularly regarding the use of generic recommendations, given the risk that they may encourage generic responses. There are undoubtedly also related changes that could be made to the practices of prison staff and coroners, yet our data speak to changes for the PPO given our interview guide's explicit focus on improving the PPO's investigations.

Whilst our findings focus on one jurisdiction, with careful attention to contextual differences, they have relevance for prisoner death investigations worldwide. International comparison of prisoner death investigations is essential to facilitate their implementation and evaluation and to acknowledge the frequency and importance of prisoner deaths (see Bugeja et al. 2015). Our dialogical approach in this article begins to highlight the importance and implications of exploring competing constructions of the causes of carceral crises, which others could valuably extend across prisons and detention oversight bodies in different jurisdictions. Future scholarship on prison and detainee deaths, for instance, could make international comparisons between the agencies that undertake internal and external prisoner and detainee death investigations; the order in which various investigations are carried out and the relationships between them; the legal status of investigating agencies; how deaths are identified; whose constructions and policies are heard and obscured in investigations; and if and how investigation findings inform prison and detention monitoring more broadly.

Taken together, this article also raises important theoretic-practical implications for scholarship and practice on the monitoring of coercive institutions. Although detention monitoring is held in high regard and promoted in international human rights norms and practice (see O'Connell and Rogan 2022; Kemp and Tomczak 2023), we have demonstrated the importance of vigorously contesting conceptualizations of prison oversight activities as an unqualified "good." Even under the United Kingdom's dense detention-monitoring approaches, detainees continue to die preventable deaths in similar circumstances (Coles and Shaw 2012). Recognizing and grappling with this reality is likely to be more productive than repeatedly celebrating the value of oversight. We seek to encourage exploration of the limitations of prison oversight bodies and their activities in new and multidisciplinary ways, capitalizing on the power of multisectoral actors to influence organizational processes (Goodman, Page, and Phelps 2017) in order to map more optimistic ways ahead (Tomczak 2022a). We now outline core considerations to underpin the requisite theoretic-practical agenda on prison monitoring, drawn from our research on prisoner death investigations in England and Wales.

First, our research has underscored the importance of interrogating what is not or cannot be said and written by prison overseers. Advancing socio-legal understandings of these "silences" will mean asking questions such as: what legal, jurisdictional, and organizational factors and structures constrain the form and content of what is reported by prison-monitoring bodies; whose perspectives are excluded from oversight activities; which harms remain unacknowledged; and in what ways do these "silences" matter for the outcomes of prison oversight? Second, socio-legal scholarship on prison monitoring must carefully consider how oversight bodies construct the scope of the problems they investigate and envision the scale of the solutions they propose. This will involve posing questions such as: what are the boundaries (that is, temporal, institutional, geographic) of prison investigations; how is causality conceptualized within these investigations;

what does it mean to hold someone or something responsible for problems within prisons; what forms of change are considered meaningful; and what evidence is there that prison monitoring is leading to (systemic) improvements? Third, and finally, we encourage socio-legal scholars to place prison monitoring's multiple stakeholders in dialogue. Extending the dialogical work that we have begun in this article will mean asking questions such as: what is the relationship between prison overseers and those who are overseen; how do these relationships facilitate or frustrate change within prisons; what happens amidst competing constructions of problems and solutions; and how do dense prison-monitoring approaches (not) interact? Struggles between actors create penal change (Goodman, Page, and Phelps 2017). In revealing how diverse penal actors differently construct prisoner death investigations, this article has challenged taken-for-granted assumptions about these processes, has offered possibilities to reformulate prisoner and detainee death investigations, and has revealed new points of intervention for detention oversight mechanisms that could mediate conditions and rates of imprisonment around the world.

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