Prisoner Death Investigations: Setting the Agenda for Change

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There are around 11.5 million prisoners globally. Amongst prisoners, mortality rates are as much as 50 per cent higher than in the outside community, although prisoner mortality has received relatively limited scholarly attention.[1] All deaths in state detention threaten the fundamental human right to life so must be investigated under (inter)national law. For example, Article 2 of the European Convention on Human Rights includes a duty to investigate potential violations of the right to life within the Council of Europe's 47 member states. Death investigations have significant potential to reduce the extensive harms and costs of prisoner deaths, but these investigations have barely been analysed or developed internationally.[2] This article reports findings from a research project exploring how the Prisons and Probation Ombudsman in England and Wales (PPO) (seek to) effect change and improve prison safety through their investigations, particularly for self-inflicted deaths.

Prison suicides cause (enduring) harm across stakeholders including bereaved families, prisoners, prison staff and death investigators, and negatively affect staff wellbeing, absence, and prison regimes.[3] Suicides in locales can also lead to further deaths through 'clustering', potentially compounding the risks, harms, and costs of each death. 'Clustering' can result from changes to prisoner behaviour, regime disruptions and changes in staff practice, such as increased fear and risk aversion after deaths.[4] Given the substantial harms and costs of prison suicide, it is urgent and essential to establish how investigations could more effectively prevent some deaths. In England and Wales, self-inflicted death rates amongst prisoners more than doubled between 2012 and 2016, when they hit record numbers: creating widespread harm and draining hundreds of millions of pounds from public funds.[5] England and Wales are in the 'very high' categories for both prison suicide rate and imprisonment rate amongst their European comparators, according to the most recent SPACE 1 figures.[6] Annual reports consistently highlight that the PPO make the same recommendations to the same identified failings and that fatal incident investigations do not make prisons safer overall.[7] Our research project has indicated reasons for this impasse, illustrating many new opportunities for analysis and action, which have been published in summary and long form.[8] In this article, we advance these publications by highlighting foundational areas that require attention: the underpinnings or bases upon which PPO investigations and clinical reviews are undertaken.

Prisoner death investigations have evolved over time and been affected by various factors, including

1. UNOHCHR (2019) *Human rights in the administration of justice.* http://fileserver.idpc.net/library/OHCHR%20-%20Human%20rights%20in%20admin%20of%20justice%20A_HRC_42_20.pdf
2. Correctional Service Canada (2018) *Fourth Independent Review Committee on Non-natural Deaths in Custody.* https://www.csc-scc.gc.ca/publications/092/005007-2310-en.pdf
3. Banwell-Moore R, Tomczak P Wainwright L, Traynor C and Hyde S 'The human toll': Highlighting the unacknowledged harms of prison suicide which radiate across stakeholder groups. *Incarceration 3*(2): 1–20. https://doi.org/10.1177/26326663221097337
4. Tomczak P (2022) Highlighting 'risky remands' through prisoner death investigations: people with very severe mental illness transitioning from police and court custody onto remand. *Frontiers in Psychiatry 13*. https://doi.org/10.3389/fpsyt.2022.862365
5. Tomczak P (2021) Reconceptualizing multisectoral prison regulation: Voluntary organisations and bereaved families as regulators *Theoretical Criminology OnlineFirst*. https://doi.org/10.1177/1362480621989264
6. Council of Europe (2021) *Prison Populations: Space 1*. https://wp.unil.ch/space/files/2022/05/Aebi-Cocco-Molnar-Tiago_2022__SPACE-I_2021_FinalReport_220404.pdf
7. PPO Annual Reports. https://www.ppo.gov.uk/document/annual-reports/
8. See also: i) Tomczak P and Banwell-Moore R (2021) *Prisoner death investigations: Improving safety in prisons and societies? Summary of findings* https://www.safesoc.co.uk/wp-content/uploads/2021/10/UoN_Prisoners_Death_Investigation_Report-FINAL-WEB-VERSION.pdf;

iii). Tomczak P and Cook E (2022) Bereaved family 'involvement' in (prisoner) death investigations: whose 'satisfaction'? *Social and Legal Studies OnlineFirst* https://doi.org/10.1177/09646639221100480;

iv). Tomczak P, Quinn K, Traynor C, Wainwright L and Hyde S (forthcoming) Reconstructing individualised prisoner death investigations: naming the Prisons and Probation Ombudsman's silence on systemic hazards found across the national prison estate.

e.g., the implementation of the *Human Rights Act 1998,* particularly the Article 2 requirement for independent investigations. At present, both PPO death investigations and clinical reviews inform coroners' inquests. Inquests are robustly underpinned by law and are only concerned with matters that caused or contributed to the circumstances in which people died. The PPO ostensibly works 'together with coroners to ensure as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are made clear'.[9] NHS England or the Healthcare Inspectorate of Wales commission clinical reviews, which investigate the clinical issues relating to deaths in custody. The PPO incorporate clinical reviews into their fatal incident investigation reports, which are provided in draft form to coroners and interested parties, and then published on the PPO's website after the inquest has concluded. In this article, we demonstrate that the underpinnings, or bases for PPO reports and clinical reviews are currently unclear, perhaps as a result of the piecemeal evolution of prisoner death investigations. We argue that increased transparency about the bases upon which both these investigations are undertaken and draw conclusions would have valuable implications that reach across stakeholder groups.

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We demonstrate that, in practice and implicitly, the PPO investigate the compliance of staff in individual prisons with local and national prison policy. Clinical reviewers seem to focus on compliance with NHS and prison policy and examine whether deceased prisoners' care was equivalent to care in the community in a general sense, without having specialist understanding of particular diseases.[10] Because the PPO, clinical and coroner investigations into each death overlap and diverge, it is particularly important that they are undertaken with a transparent basis, that all stakeholders can understand. It would also likely be useful for the PPO and clinical review bodies to reappraise their bases and the assumptions underpinning their work, reconsidering their utility to prisoner death prevention and coherent prisoner death investigations. We conclude that the PPO could valuably either revise its *Terms of Reference* to reflect its existing investigation of staff compliance with local and national prison policies or broaden its activities in order to do what its *Terms of Reference* imply.

Methodology

This project resulted from a collaboration between the University of Nottingham and the PPO beginning in early 2019, which sought to strengthen the PPO's impact on prison safety by shifting focus from outputs (investigating every death and producing reports of those investigations) to outcomes (how the PPO could make it more likely that reports would lead to change and improvement). This article reports findings from this project, which ran from 2019-2021, examining how the PPO seek to impact prison safety through death investigations. Within this project, 45 semi-structured interviews were undertaken with diverse stakeholders in England and Wales including Coroners, PPO staff, prison staff and bereaved families. In this article, we focus on data from interviews with nine Coroners. Coroners are scarcely empirically researched, so their perspectives offer particularly original data.[11] Moreover, Coroners made the most fundamental critiques of the PPO's operating assumptions, perhaps because Coroners have more distance from deaths than the other participant groups.

The semi-structured interview technique enabled participants to express complexities in their answers and generated rich data. Nine coroners volunteered to participate following an invitation sent to all area Coroners in England and Wales. Interviews were undertaken in Summer 2020 via telephone or Microsoft Teams, due to the COVID-19 pandemic. Our sample was purposive and participation was self-selecting, which is appropriate for this exploratory analysis in a novel area of inquiry, but as such we make no claim to representativeness across coroners. Ethical approval was obtained from the University of Nottingham. Interviews lasted between 30 and 75 minutes and were all audio recorded with participants' consent. Data have

9. PPO (2021) *Terms of Reference,* p. 9-10 https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/12/PPO-2021-Terms-of-Reference.pdf
10. https://www.england.nhs.uk/wp-content/uploads/2018/10/non-foreseeable-death-clinical-reviewer-template.doc
11. Baker D (2016) Deaths after police contact in England and Wales: the effects of Article 2 of the European Convention on Human Rights on coronial practice. *International Journal of Law in Context,* 12, 162-177.

been anonymised. Interview topics included: i) how the PPO seeks to effect change in prisons following a death, ii) whether these actions had the intended effects and iii) if and how the PPO adjusts its actions to better effect change. Coding of transcripts produced the prevalent themes across participants. Anonymised interview transcripts for participants who consented to data sharing, plus supporting information, are available from the UK Data Service, subject to registration (DOI: 10.5255/UKDA-SN-855785). We now explore our findings.

Results

Lack of an explicit basis for PPO findings

Coroners explained how PPO reports provided a useful 'starting point' for inquests, helping generalist coroners to navigate specialist 'prison files' and signpost, without determining, issues for the inquest.

> *CORONER 1 They are giving you a very good starting point, […] picking up on those issues which obviously become significant issues for the Inquest, […] a foundation point.*

> *CORONER 2 It gives you an overview. […] I wait for the report to come in and it gives me a flavour of what's happened.*

The PPO report is an important offering to inform the inquest because of the nature and complexity of deaths in prisons, amidst circumstances which can be challenging for outsiders to fully grasp:

CORONER 6 I wouldn't dream of doing an unnatural death in prison without one.

Despite these valuable contributions, the current focus of PPO investigations is akin to an internal organisational review, which potentially results from the PPO's predecessor internal Prison Service death investigations as undertaken before 2004. In practice, the PPO's investigations and findings almost always focus on frontline prison staff compliance with local and national prison service policies.[12] Coroner 8 considered that the PPO report was effectively a review for the Prison Service, although this is not explicitly stated by the PPO.

> *CORONER 8 It's (the PPO report) a framework within which to formulate my own investigation, my own questions, my own direct line of inquiries (the inquest). […] They (the PPO) are directed at […] the Prison Service, really.*

It is problematic that the PPO's relatively narrow practice of examining compliance with local and national Prison Service policy is not reflected by its Terms of Reference, which are worded expansively.

It is problematic that the PPO's relatively narrow practice of examining compliance with local and national Prison Service policy is not reflected by its *Terms of Reference,* which are worded expansively. The PPO ostensibly seeks: 'to ensure […] that the full facts are brought to light and […] examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence.[13] In practice, the PPO rarely engages with issues not covered by prison service policies. This means that, for example, bereaved families' questions may not be answered (e.g., why their relative was not sectioned in hospital rather than imprisoned)[14] and means that the PPO misses opportunities to highlight systemic issues, such as the remanding of people with severe mental illness to prison rather than hospital.[15]

By way of illustration, the sad case of Mr Lewis Francis is useful. Mr Francis died at 20 years old whilst remanded at HMP Exeter, England on 24th April 2017. His alleged crime occurred whilst he was acutely psychotic, on 15th February 2017 and continuing psychosis meant he was deemed unfit to be interviewed by Avon and Somerset Police at Bridgwater

12. Tomczak P and McAllister S (2021) Prisoner death investigations: a means for improving safety in prisons and societies? *Journal of Social Welfare and Family Law. 43*(2), 212-230, https://doi.org/10.1080/09649069.2021.1917714
13. PPO (2021) *Terms of Reference,* p. 9-10 https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/12/PPO-2021-Terms-of-Reference.pdf
14. Tomczak P and Cook E (2022) Bereaved family 'involvement' in (prisoner) death investigations: whose 'satisfaction'? *Social and Legal Studies OnlineFirst* https://doi.org/10.1177/09646639221100480
15. Tomczak P (2022) Highlighting 'risky remands' through prisoner death investigations: people with very severe mental illness transitioning from police and court custody onto remand. *Frontiers in Psychiatry 13*. https://doi.org/10.3389/fpsyt.2022.862365

Custody Suite. On 17th February 2017, the day of Mr Francis' remand to prison, a doctor recorded that he was 'agitated and distressed […], displayed evidence of thought disorder and […] was severely disinhibited'.[16] This doctor recorded 'serious concerns as to whether prison was an appropriate environment for Mr Francis […]', pointing out that the pre-custody psychiatric report 'did not give a clear reason why Mr Francis was processed through the criminal justice system'. This prison doctor 'asked for an urgent mental health assessment to be carried out', however this 'urgent' assessment, which could have facilitated secure hospital treatment, was not carried out before Mr Francis' self-inflicted death. Mr Francis was therefore imprisoned between 17th February and 24th April 2017 without a criminal conviction, whilst acutely unwell and without having had a mental health assessment. Significantly, the PPO report made no recommendations in Mr Francis' case, given that prison staff had appropriately referred him for a mental health assessment and that HMP Exeter had complied with local and national prison policies in this case. Although the PPO report notes that 'Mr Francis' mother wanted to know what consideration, if any, was given to sectioning her son under the Mental Health Act', the PPO neither engaged with this substantive issue nor addressed its absence in their published report.[17] According to Coroner Rheinberg,[18] whilst in police custody, Mr Francis' condition 'mandated a transfer to a medium secure mental health hospital for an assessment and/ or treatment under section 2 and / or 3 of the Mental Health Act 1983'. Nevertheless, no ready facility existed for such a transfer, meaning that Mr Francis was remanded to prison. In contrast to zero recommendations from the PPO, Coroner Rheinberg made a series of findings in a prevention of future deaths report. Without understanding that the PPO currently assess compliance with local and national prison service policies, it is challenging to make sense of the diverging findings of the PPO report and the inquest, which may confuse prison staff and affect the trust and confidence of bereaved families in the process.

Moreover, Coroners, a core audience with whom the PPO should be 'working together' per their own *Terms of Reference*, were themselves not clear about the basis for the PPO's investigations.

> *CORONER 9 I don't know if I have a handle on what the goal really is of them sometimes. I read the Terms of Reference and I'm sometimes thinking okay…..*

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Relatedly, Coroner 3 explained that the PPO were not sufficiently transparent about their processes and the burden of proof applied in their investigations and reports.

> *CORONER 3 There are uncertainties as to the standard of proof. […] I'm from a legal background, so I'm concerned to establish that we prove everything, […] the balance of probabilities, […] whereas I've no idea what standard the PPO works to because it's never made plain in their investigations. […] I don't know how they conduct things, how much they press or challenge, whereas in my Courts, the evidence is given on oath or affirmation. (emphasis added).*

These disconnects and uncertainties are amplified in importance because the PPO and Coroner essentially undertake 'parallel' investigations into each prisoner death (Coroner 5), meaning that there is substantive potential for confusion and mistrust, which makes it particularly important for all parties to be transparent:

> *CORONER 3 The overarching concern that I've got is […] overlapping inquiries. […] I have a*

16. P6 of PPO (2018) *Independent investigation into the death of Mr Lewis Francis a prisoner at HMP Exeter on 24 April 2017*. https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2020/03/F3141-17-Death-of-Mr-Lewis-Francis-Exeter-24-04-2017-SI-18-21-20.pdf
17. P3 of PPO (2018) *Independent investigation into the death of Mr Lewis Francis a prisoner at HMP Exeter on 24 April 2017*. https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2020/03/F3141-17-Death-of-Mr-Lewis-Francis-Exeter-24-04-2017-SI-18-21-20.pdf
18. Rheinberg N (2020) *Regulation 28: Report to prevent future deaths.* Retrieved from https://www.judiciary.uk/wp-content/uploads/2020/04/Lewis-Francis-2020-0074.pdf

statutory duty to investigate a death. Now the PPO then comes along and carries out their own investigation, reaches conclusions. […] So […] there's a risk that we will get in a bit of a muddle. […] We need to be clear as to what exactly is our mission, when we have people in different orbits and different timescales applying different rules.

Whilst Coroners are working to remits set out in law, the PPO's remit is less clear.

CORONER 2 My statutory requirements are 'how the person' died but their remit is slightly different.

As such, the PPO considers factors that *did not cause the death* and made recommendations that were not directly linked to the death, hence fall beyond the remit of Coroners. For example, the PPO considered issues such as the completion of paperwork in suicide risk management processes, e.g., recommending that staff should be 'Completing ACCT documents fully and accurately'.[19] [20] Whilst the longer PPO report usually states whether such compliance issues would have made a difference to the outcome in each death, this is not always clear in their recommendations section, where stakeholders' attention is likely to be focussed.

Whilst Coroners need to determine whether failings to follow policy caused or contributed to the death, the PPO do not always examine this.

CORONER 1 Quite often (PPO) recommendations aren't really linked to the death.

CORONER 3 Their (PPO) remit differs from mine, […] they will look at things that didn't cause the death.

CORONER 8 If I was being brutally candid, […] the (PPO) recommendations, I take less heed of. […] I'm looking at the circumstances that directly led to the cause of death. […] Because some documentation hasn't been completed properly, […] not every case will have had an impact on the circumstances of the death. […] That they haven't ticked a box on a form, it doesn't mean […]. They (the PPO) […] make recommendations […] on matters that don't go […] to the cause of death and the circumstances that directly led to the death.

It would therefore be valuable for the basis for the PPO's recommendations to be explicitly stated, and for the PPO to explore means of emphasising the procedural nature of their recommendations, to avoid implying that practice that diverged from policy necessarily contributed to a death.

Whilst Coroners need to determine whether failings to follow policy caused or contributed to the death, the PPO do not always examine this. Coroner 5 wanted the PPO and Coroner investigations to be better linked and requested that the PPO consistently consider the consequences of the failings they identified.

CORONER 5 Linking us up as the two different investigations better, that I would like us to be doing. […] They have a slightly different approach to it. […] For me, one of the key things I would like to see in the PPO Report is if it went wrong, what did that mean? Because that is the question the family is going to ask, isn't it: would that have made a difference?

All stakeholders, in particular bereaved families, deserve transparent and accurate representations of the PPO's activities. As there are multiple parallel investigations undertaken by different agencies into prisoner deaths, it is particularly important to be explicit about what is being done and why, for the benefit of all stakeholders. The PPO could therefore valuably revise its *Terms of Reference*, to more accurately reflect its practices to all stakeholders. In so doing, the PPO must consider that focussing on policy compliance as the start and end point of investigations will likely mean that attention to preventative work is peripheral at

19. Assessment, Care in Custody and Teamwork (ACCT): the care planning process for prisoners identified as being at risk of suicide or self-harm
20. P5 of https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2015/03/self-inflicted-deaths-2013-14-Final-for-publication-5.pdf

best,[21] or broaden its activities to do what its *Terms of Reference* imply. A broadened set of activities and considerations could see the PPO better effect change and improve prison safety through their investigations. Related limitations and a lack of transparency about the basis for investigations were found with clinical reviews, to which we now turn.

Lack of basis for clinical review findings

There are longstanding concerns about the quality and independence of clinical reviews,[22] and little evidence defending their existing parameters and execution, or indicating efforts to improve. Five Coroners were very critical of the clinical reviewers, highlighting their perceived lack of expertise, for example:

> *CORONER 2 The clinical review, […] you've got an issue re: expertise, they're not experts.*

> *CORONER 4 The clinical assessors, they are often nurses and they are being asked frequently to look at the decisions that had been made […] by psychological or psychiatric doctors. […] They are not always particularly robust.*

> *CORONER 8 You very often get non-specialists giving opinions on specialist matters. […] If it's a cancer diagnosis issue, get a specialist in. [….] The clinical reviewer ought to be an expert in the area before they make or give expert opinion and make recommendations. […] I've had on more than one occasion, […] a GP […] giving advice on what would be […] a Consultant Oncologist […] area of expertise.*

Whilst there may be a rationale for clinical reviews being done as they are currently, in our sample this was not made clear to Coroners, who are a core audience for the findings. Expanding, Coroner 3 considered that the clinical reviewers had insufficient experience of the context of prison medicine:

> *CORONER 3 Clinical Reviewers […] tend to be GPs who are doing a bit of session work. […] I questioned a clinical reviewer and said: well what experience have you got of prison medicine and they said: I've never worked in a prison, […] I have my knowledge and experience as a GP. Well prison medicine is different. There are different structural factors in play […] So what value does the PPO have? Well in some of these types of cases, little.*

Coroner 4 went on to describe an instance of the clinical reviewer changing their judgment at inquest. It is unlikely that this revision would then also be inserted into published PPO reports and communicated to stakeholders. Changing judgments like this might also affect the trust and confidence of bereaved families in the investigations.[23]

> *CORONER 4 I will often call the GPs myself, […] actually I'm not as confident as they often are that care was provided in accordance with that which would be provided in the community. […] One clinical investigator […] wasn't able to really justify the conclusions that had been reached and in fact through questioning, departed from the view that care provided was […] in accordance with the community standard and accepted actually there was some significant failings.*

Inadequate clinical review findings could also create delays in already lengthy inquest processes, for example if expert work had to be repeated or recommissioned.

Inadequate clinical review findings could also create delays in already lengthy inquest processes, for example if expert work had to be repeated or recommissioned. Whilst Coroner 7 accepted that funding might not be available for the PPO or Clinical Reviewer to seek an expert clinical opinion, they wanted this to be made clear 'early on'.

21. Office of the Correctional Investigator (Canada) (2014) A Three Year Review of Federal Inmate Suicides. https://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20140910-eng.pdf
22. Leach, P. (2011) *Report on the IAP's Work Stream Considering Investigations of Deaths in Custody – Compliance with Article 2* ECHR; Harris, T. (2015) *Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18–24 Year Olds* (the Harris Review). London: TSO.
23. Tomczak P and Cook E (2022) Bereaved family 'involvement' in (prisoner) death investigations: whose 'satisfaction'? *Social and Legal Studies OnlineFirst* https://doi.org/10.1177/09646639221100480

CORONER 7 The ability to get specialist outside help, […] Consultant Psychiatrists, Psychologists, Nursing experts. […] A lot of the times I have to instruct them myself because the job hasn't been done properly to start off with. […] I know there's a big issue about getting outside experts. […] If they say to me, well we would have ideally wanted to instruct an expert Psychiatrist but we are not funded to do that, […] if they were to highlight that early on, now, that would assist us.

Gaining clarity early was important, as a misguided clinical review could change the nature of the inquest, creating inefficiencies and potentially suspicion for bereaved families. Coroner 8 described an instance where a Jury inquest was unnecessarily called for a death which a specialist later deemed unpreventable.

CORONER 8 I'll get […] a GP saying: earlier intervention by a Consultant Oncologist would have prevented this, […] and then when I commission an expert report for £2,500 and they say: well that's nonsense. […] I've gone to the expense of having a Pre-Inquest Review, getting everyone together, saying: […] earlier intervention may have had an impact on the cause of death which may have altered the outcome […] and then when I do seek expert opinion, I'm told: well actually the cancer was at such an advanced stage, no treatment would have had any difference on the outcome.

Reflecting the PPO's consideration of factors that did not cause the death and recommendations that were not directly linked to the death, as explained above, Coroners highlighted the risks of diverging remits between their inquest and the clinical review. Coroners need to determine whether inadequate care caused or contributed to the death, whereas clinical reviewers examine whether deceased prisoners' care was equivalent to care in the community. This could create difficulties for Coroners if troublesome findings emerged close to the inquest hearing.

CORONER 5 The clinical review […] will often express a view about the quality of clinical care. But then […] in an Article 2 Inquest, it's not just about whether the care was adequate, it's also did that care cause or contribute to the death […] And they don't go that far […] in the clinical review. We then have to follow that up and that can be very difficult. […] Because our remit is slightly different, they don't appreciate that we need that additional evidence, so we then have to go off and get that.

Coroner 3 expanded:

CORONER 3 What's the purpose of having duplicated or overlapping inquiries? […] I'm beginning to question the wisdom of this. The risks are that different inquiries produce inconsistent outcomes.

It would therefore be most useful for the PPO and clinical reviewers to reflect on the purposes of and rationales for their investigations, to clarify exactly what they do and consider how this can converge with and diverge from Coroners' inquests. We now conclude this article by considering next steps.

Where to now?

The findings of this project were always intended to inform a practical pilot where the PPO changed its practices and evaluated the value of the changes. A pilot to test some changes to the way the PPO reports and makes recommendations could mobilise some of the findings from this project, support change and deliver improved outcomes for people and staff in prison, as well as powerfully indicating that the PPO is open to collaboration and keen to learn. Unfortunately, a pilot on this work has not yet come to fruition and the current Ombudsman, Sue McAllister, left office at the end of June 2022. Despite firm backing for the collaboration with academia and the implementation of our findings from the Ombudsman during her term, the prevailing view amongst Ombudsman staff in the fatal incidents function: that the reports were well regarded, had impact and so did not need to change, was not supported by what this project indicated. We hope that the incoming senior PPO team will find energy and motivation to take this work forwards, for the benefit of prisoners, prison staff, families, and societies.[24]

24. Tomczak P (2021) Reconceptualizing multisectoral prison regulation: Voluntary organisations and bereaved families as regulators *Theoretical Criminology OnlineFirst.* https://doi.org/10.1177/1362480621989264