University of Nottingham
UK | CHINA | MALAYSIA

prisonDEATH
DEATHS IN PRISON WORLDWIDE

25th March 2022

SUBMISSION: Older persons deprived of their liberty

4. Could you give us an **overview on the national and local legal frameworks** which prevent and protect older persons deprived of their liberty from human rights violations? Are there effective and available national monitoring and accountability mechanisms? Please provide a detailed answer with supporting information/documents.

5. Please share examples of **good practices** on how to ensure that older persons deprived of their liberty can exercise their human rights.

Investigations undertaken by the Prisons and Probation Ombudsman into all prisoner deaths are a core national accountability mechanism in England and Wales. This mechanism is readily *available* but there are serious doubts as to its *effectiveness.* Central concerns examined here are i) the very limited impact of investigations on practice, ii) compromised follow up monitoring processes and iii) the lack of an explicit evidence base to underpin PPO recommendations (Tomczak, forthcoming; Tomczak and Banwell-Moore, 2021; Tomczak and McAllister, 2021; Tomczak, 2021; Tomczak, 2018).

Regarding the very limited impact of investigations, the PPO's "most frequent recommendation" concerns the inappropriate use of restraint for older, dying prisoners, as recommended in more than half of their death investigation cases and frequently repeated to the same prisons after remedial action had been agreed (PPO, 2017: 16). Routine restraint risks infringing Article 3 of the European Convention on Human Rights (ECHR) (following *R (on the application of Graham) v Secretary of State for Justice* [2007] All ER (D) 383 (Nov). A PPO learning lessons bulletin on this topic from 2013 can be seen

here[1]. Very recent examples of cases which stimulated this recommendation are available here[2], here[3], here[4] and here[5]. Given this widespread poor practice regarding restraint after PPO efforts and recommendations over many years, it is hard to see how the PPO's work effectively protects this right. I have written about the need to move beyond simply highlighting that 'recommendations are not implemented' and instead *question what overseers recommend, based on which evidence* (e.g. Tomczak, forthcoming). Moreover, highlighting the harms and costs of death investigations (see Tomczak and Banwell-Moore, 2021), Robinson (2021) illustrates some unintended negative consequences of prison staff anticipating PPO investigations whilst Peay (1996: 30) argues that detriment to those "awaiting and undergoing the process […] can only be weighed against the effectiveness of […] conclusions and recommendations".

The PPO's focus on recommendations regarding restraint also risks deflecting attention from substantive issues: including generalised acceptance that increasing numbers of people will age (in an accelerated way, with earlier onset of health problems (PPO (2017: 10)) and then die in prisons. Fundamental consideration of the necessity and acceptability of this situation is required. As the PPO note (2017: 3):

> "prisons designed for fit, young men must adjust to the largely unexpected and unplanned roles of care home and even hospice. Increasingly, prison staff are

[1] https://www.ppo.gov.uk/app/uploads/2014/07/LLB_FII_Restraints_web_version.pdf
[2] https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2022/02/F5777-21-Death-of-Mr-Michael-Boyd-in-hospital-Leeds-31-08-2021-NC-60-70.pdf
[3] https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2022/02/F5707-21-Death-of-Mr-Anthony-Kadri-Norwich-03-06-2021-NC-60-67.pdf
[4] https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2022/03/F5681-21-Death-of-Mr-Robert-Constable-Bure-06-05-2021-NC-60-87.pdf
[5] https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/09/F5660-21-Death-of-Wyn-Davies-Frankland-NC-18-04-2021-69.pdf

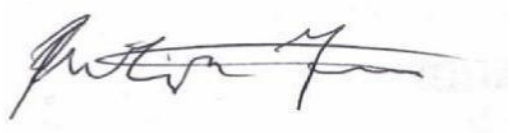
> having to manage not just ageing prisoners and their age-related conditions, but also the end of prisoners' lives and death itself – usually with limited resources and inadequate training".

Regarding compromised follow up monitoring, PPO investigations have been undertaken since 2004 to support compliance with Article 2 of the ECHR. PPO findings inform Coronial inquests. Whilst the PPO and Coronial investigations overlap, their findings are published separately, produced with different aims and methodologies, and may ultimately bear little relationship to each other. The value of these overlapping and diverging investigations is questionable. Inquests are underpinned by legislation and case law, whereas the PPO operates using Terms of Reference and Memoranda of Understanding that are worded obscurely. In a recent extensive study of the impacts of PPO investigations (Tomczak and Banwell-Moore, 2021), one Coroner commented: "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….." (Coroner 9). Coroners consider the means and circumstances of each death, but in practice (although this is not explicitly stated in e.g. their Terms of Reference) the PPO primarily make findings regarding compliance with local and national prison service policies, potentially indicating that the PPO's practices have not diverged sufficiently from its predecessor internal Prison Service investigations. The PPO's findings alone also inform the follow up work undertaken by Her Majesty's Inspectorate of Prisons which is peculiar and means that there is a lack of follow up on Coroners' recommendations.

Regarding the lack of an explicit evidence base to support PPO investigations, it would **be good practice for oversight bodies** such as the PPO to develop transparent and accessible Terms of Reference. These should clearly explain core aspects of oversight bodies' operations such as i) their evidence bases, ii) the burden of proof applied in reaching conclusions, iii) what they can and cannot examine (e.g. decisions about recall to prisons) and iv) a realistic explanation of what impacts investigations might have in practice, such that e.g. bereaved families can make an informed decision about whether to participate. At present the PPO's Terms of Reference are expansive and incorrectly imply that the PPO work to ensure that "any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are made clear" (PPO, 2017: 9). In practice the PPO's remit is constrained and bereaved families may be left distressed by lack of consideration of e.g. recall decisions and prisoner mental capacity upon reception to prison. In a recent extensive study of the impacts of PPO investigations (Tomczak and Banwell-Moore, 2021), one Coroner argued that the PPO were not **sufficiently transparent about the burden of proof they applied**: "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" witnesses (Coroner 3). Moreover, attention to the letter of human rights law is likely to be insufficient for rights protection in practice, so engagement with e.g. organisational scholarship on learning from adverse events and the stakeholders charged with frontline rights protection about the barriers they face is required.

I have also supplied an example of good practice as identified by the PPO (2017: 27). The PPO have applauded the creation of specialised palliative care facilities in prisons where doors can be unlocked, healthcare staff can have unrestricted access to the prisoner and staff have access to adequate equipment and resources. Whilst some prisoners do want to die in prison as it is effectively their 'home', I wish to again highlight the substantive need to reconsider the generalised acceptance of increasing proportions of people ageing and dying in prison.

I am of course more than happy to discuss this work further and am very interested in research you conduct and events that you host on this topic during your term of office.



Dr Philippa Tomczak BA/ MA (Oxon) MSc (Oxon)
Principal Research Fellow, *prison*HEALTH Research Group Director
University of Nottingham School of Sociology and Social Policy

prisonHEALTH
PRISONS, HEALTH AND SOCIETIES RESEARCH

Contact: philippa.tomczak@nottingham.ac.uk

Dr PHILIPPA TOMCZAK: UK Research and Innovation Future Leaders Fellow examining *Prison Regulation, for Safer Societies* and commencing a European Research Council Starting Grant on *Regulating Criminal Justice Detention* in 2022. Philippa directs the Prisons, Health and Societies research group and undertakes research and impact work with the Prisons and Probation Ombudsman in England and Wales, involving interviews with: prisoners, Ombudsman staff, prison staff, Coroners and bereaved families and extensive document analysis. Progress is reported here.

References

Peay J (1996) Themes and questions: the inquiry in context, in Peay J (Ed) *Inquiries after Homicide*. London: Duckworth, pp 9-38.

PPO (2017) *Older Prisoners*. London: PPO.

Robinson C (2021) The anticipation of an investigation: The effects of expecting investigations after a death from natural causes in prison custody. *Criminology & Criminal Justice*, OnlineFirst.

Tomczak P (2022, in press) Highlighting "risky remands" through prisoner death investigations: people with very severe mental illness transitioning from police and court custody into prison on remand. *Frontiers in Psychiatry – Forensic Psychiatry*.

Tomczak P (2021) Reconceptualizing multisectoral prison regulation: Voluntary organisations and bereaved families as regulators. *Theoretical Criminology* OnlineFirst.

Tomczak P and Banwell-Moore R (2021) Prisoner death investigations: improving safety in prisons and societies? https://www.safesoc.co.uk/wp-content/uploads/2021/10/UoN_Prisoners_Death_Investigation_Report-FINAL-WEB-VERSION.pdf

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.

Tomczak P (2018) *Prison Suicide: What Happens Afterwards?* Bristol: University of Bristol Press.