Bereaved family 'involvement' in (prisoner) death investigations: whose 'satisfaction'?

Abstract

A duty to investigate deaths in detention is enshrined within international legislation including Article 2 of the European Convention on Human Rights. A core purpose of these investigations, following UK case law, is that bereaved families 'have the satisfaction of knowing that lessons learned […] may save the lives of others.' We highlight the striking absence of evidence illustrating the 'satisfaction' of bereaved families, utilising a case study of prisoner death investigations undertaken by the Prisons and Probation Ombudsman and Coroners in England and Wales. Drawing on data from semi-structured interviews with 26 stakeholders, we explore what may produce familial 'satisfaction' and question *who is satisfied* by prisoner death investigations. Our analysis demonstrates that bereaved family 'satisfaction' was regularly spoken about by investigators and invoked to legitimise investigations despite limited evidence thereof. In conclusion, we highlight how the Ombudsman and Coroners should reconsider their practices to better satisfy families and manage expectations.

Keywords

families, death, bereavement, prisons, inquests, suicide, detention

Introduction

Prisoner deaths form an enduring topic of (inter)national, multidisciplinary concern (Sattar and Killias, 2005). More than 11 million people are imprisoned globally, of whom 30% have not been convicted (Penal Reform International, 2021). Prisoner mortality rates exceed rates in the general population by up to 50% (UNOHCHR, 2019: p9) and 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). (Inter)national laws impose obligations on States to investigate all prisoner deaths (and all deaths in compulsory state detention e.g., criminal, psychiatric, immigration) as suspected violations of the right to life (OHCHR, 2017; Rogan, 2018). In October 2021, the UN Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz, identified deaths in custody amongst his four priority areas and stressed the importance of death investigation systems in preventing and resolving unlawful deaths worldwide. Tidball-Binz stated: "most deaths in custody are preventable.

However, they are seldomly investigated properly [...], which helps perpetuate this tragedy"[1]. Death investigations, underpinning legal frameworks and evidence bases have not attracted attention reflecting their importance and harm reduction potential (inter)nationally (Tomczak and McAllister, 2021).

Bereaved families' experiences of death investigations deserve sustained analysis, as "ultimately those who are left to embrace the inquest's benefits, or bear its failings, are the bereaved" (Scott Bray and Martin, 2016: p. 136). Globally, S.10 of the *Minnesota Protocol on the Investigation of Potentially Unlawful Death: United Nations Manual* (OHCHR, 2017) highlights that bereaved relatives "have the right to equal and effective access to justice […] and to have access to relevant information concerning the violations and relevant accountability mechanisms". In the 47 Council of Europe member states, all deaths in compulsory state detention that are unexplained or related to violence and self-harm automatically engage Article 2 of the European Convention on Human Rights (ECHR). Article 2 protects the right to life and includes a free-standing procedural obligation to investigate potential violations. The form and nature of an investigation under Article 2 varies across jurisdictions but must meet multiple criteria, including involving the next-of-kin to the extent necessary to safeguard their 'legitimate interests' (Owen and Macdonald, 2015; ECtHR, 2015).

The adequacy of death investigation law and policy has been questioned internationally (Scott Bray and Martin, 2016). Many (former) British Commonwealth states utilise Coronial inquests to investigate unnatural deaths (Spillane et al., 2019; Evans, 2021). Coronial reforms have recently been seen in jurisdictions including the UK, Australia, Canada and New Zealand (Newhouse et al., 2020; Scott Bray and Martin, 2016). In the UK, Coronial reforms were stimulated by human tissue

[1] https://reliefweb.int/report/world/un-expert-states-have-duty-probe-all-suspicious-deaths

retention controversies from the late 1990s; the failure to detect Dr Harold Shipman's serial killings from the 1970s until the late 1990s due to flawed death certification processes; the provisions of Article 2, which has had a "dramatic effect on inquest law" (Kirton-Darling, 2016: p12); and the 2012 High Court quashing of the original inquest verdicts into the 96 deaths at the Hillsborough Stadium disaster in 1989 (Scott Bray and Martin, 2016). All of these issues stimulated the *Coroners and Justice Act 2009*, which highlighted that bereaved families require better recognition, designated families as interested persons at inquests with provisions including: being informed of post-mortem(s) and hearings; disclosure of statements and reports; and to attend and question witnesses at hearings (Ministry of Justice, 2020). These more participatory roles for families are a significant departure from the traditional UK inquest characterised by medical and legal expertise, but have attracted little scholarship (Kirton-Darling, 2016; Easton, 2020). In Australia, families have also been prominent in coronial reforms across states. For example, the *Victoria Coroners Act 2008* S.8 acknowledges that protracted proceedings can be countertherapeutic and recognises families in terms of access to information and respect for religious and cultural beliefs. Regarding autopsies, the *Queensland Coroners Act 2003* S.19 requires that, where practicable, Coroners must consider distress for families regarding an order for and the extent of internal examination of the body (Scott Bray and Martin, 2016). However, families have long acted to shape death investigations and institutional responses (Pievsky, 2005; Hay, 2006; Scraton, 2016), and family participation has often been fought for, rather than simply bestowed by legislators (Tomczak, 2021). We address the striking absence of evidence illustrating bereaved family 'satisfaction' with prisoner death investigations using the case study jurisdiction of England and Wales.

Presenting data from semi-structured interviews with 26 stakeholders, we explore notions of familial 'satisfaction' and question *who is satisfied* by prisoner death investigations in their current form. We develop a 'gap study' (Gould and Barclay, 2012), exploring gaps between family participation in prisoner death investigations 'on the books' and 'in action' by considering legal

frameworks and empirical evidence including investigators' perceptions. In England and Wales, there were 300 prisoner deaths in 2018 - 2019, i.e., a self-inflicted death every four days (INQUEST, 2020). Suicide rates more than doubled between 2012 and 2016, following 'workforce [. . .] efficiencies' (Ministry of Justice, 2016: 41). Each prisoner death triggers a series of interrelated investigations by at least the police, Prisons and Probation Ombudsman (PPO) and Coroner (Tomczak, 2018). Whilst our findings focus on one jurisdiction, they have relevance for death investigations in other countries and prisoner death investigations worldwide, although careful attention to contextual differences is required. Our findings illustrate the need to develop a rigorous theoretical agenda to underpin family involvement in death investigations, and an ethically produced evidence base to account for varying experiences thereof. We now examine legal frameworks.

Investigating potential violations of the right to life

Legal frameworks

In England and Wales, the inquest usually concludes a series of investigations into each prisoner death (Tomczak, 2018). The European Court of Human Rights, UK legislation and case law are ambiguous about who is included in the category of 'next-of-kin' or 'family', and the activities required to safeguard their 'legitimate interests' (Owen and Macdonald, 2015). In *Jordan v United Kingdom* 24746/94 [2001] ECHR 327, the Court affirmed that, for Article 2 investigations the 'next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard [their] legitimate interests' (para. 109). Whilst the judgment did not define what these interests are, it indicated that a financial or civil remedy would be insufficient. The Court doubted that the 'applicant's interests as next-of-kin were fairly or adequately protected' (para. 34) due to their inadequate access to legal representation and inadequate disclosure of witness statements. Bereaved families have now been given a right to disclosure of key documents under the *Coroners (Inquests) Rules 2013*. The opportunity to pose questions during the investigation has also been

deemed necessary to safeguard 'legitimate interests.' In addition, in *Edwards v UK* 46477/99 [2002] ECHR 303, because the bereaved parents did not have the ability to put questions to witnesses at the private hearing, they were not able to safeguard 'their legitimate interests'.

Case law has also referred to the bereaved attaining 'satisfaction' from investigations. *R v Secretary of State for the Home Department ex p Amin* [2003] UKHL 51 resulted from sustained legal challenges by Imtiaz Amin, the uncle of Zahid Mubarek who was murdered at Feltham Prison in 2000 by his racist cellmate. The judgment in *Amin* characterised the inquest as "providing a space for family participation" (Kirton-Darling, 2016: p91) and summarised the purposes of Article 2 investigations as:

> to ensure so far as possible that the full facts are brought to light, that culpable and discreditable conduct is exposed and brought to public notice, that suspicion of deliberate wrongdoing if unjustified is allayed, that dangerous practices and procedures are rectified, and that those who have lost their relative may at least have the *satisfaction of knowing that lessons learned from his death may save the lives of others* (emphasis added).

Lord Slynn (para. 41) also explained that the investigative duty extended beyond the next-of-kin to others who might be vulnerable and whose lives might need to be protected. However, the components of 'satisfaction' were not detailed.

More recently, regarding the related category of psychiatric patients, *R (Letts) v Lord Chancellor* [2015] EWHC 402 (Admin) (para. 59) found that:

> The right or legitimate interest of the next-of-kin to involvement in the procedure is viewed as a concomitant of the imperative for there to be an element of public scrutiny of the investigation in order to secure accountability. This in turn is an ingredient of the overriding need to maintain public confidence in the adherence of the State to the rule of law and to prevent any appearance of collusion in or tolerance of unlawful acts.

Here the 'legitimate interests' of the bereaved involve (procedural) public confidence in the death investigation. In international guidance, the *Minnesota Protocol* (OHCHR, 2016) goes further, with S. 28 highlighting that "investigators and investigative mechanisms must be, and must be seen to be, independent of undue influence. They must be independent institutionally and formally, as well

as in practice and perception, at all stages". This affirms the need for the actual and perceived independence of the investigation. Whilst these legal provisions give some indications of what constitutes 'legitimate interests', these may differ substantively from what bereaved families consider *to be in their own* interests. Ambiguities regarding the nature and purposes of family involvement (Robinson, Rees and Dehaghani, 2019; Rowlands and Cook, 2021), along with the multiple, potentially conflicting aims of death investigations amplify the need for empirical evidence on these issues.

Whilst law underpins Coroners' inquests, specialist investigations have less transparent foundations. Regarding prisoner death investigations, the PPO has, per its non-statutory terms of reference, assisted the inquest since 2004 to fulfil the Article 2 investigative obligation, working "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" (PPO, 2017: p9). Whilst extended police investigations are unusual for self-inflicted or 'natural' prisoner deaths, the PPO and Coroners examine every case, hence form our focus here. Operating at the "intersections of public administration and administrative law", Ombudsmen perform important accountability functions and "hold substantive potential to shape imprisonment" around the world, but are little analysed (Tomczak and McAllister, 2021: p213; see also Padfield, 2018). The PPO's terms of reference currently include bereaved families only in terms of being recipients for draft and final fatal incident reports (PPO, 2017: p10 - 11), although we explain below that its practice is more extensive. In contrast with the provisions of *Amin*, the PPO loosely defines its investigation as seeking to "provide explanations and insight for the bereaved relatives" (PPO, 2017: p9). Explanations for the PPO's lack of impact on prisoner death numbers often leverage its lack of enforcement powers (or 'teeth') and statutory footing, but in fact its flexible remit could better facilitate 'satisfaction' for bereaved families (Tomczak, 2022).

Empirical evidence

Little is known about how different death investigations intersect and how families experience them. Qualitative studies are beginning to document family experiences of investigations into, for example, fatal work incidents (Ngo et al., 2018: Australia; Snell and Tombs, 2011: UK) and suicides (Spillane et al., 2019: Ireland). Regarding specialist investigations, which sometimes inform inquests in England and Wales, family experiences have been considered in, for example: Serious Case Reviews, when a child dies or is seriously harmed as a result of abuse or neglect (Morris et al., 2015); Domestic Homicide Reviews, when the death of a person aged 16 or over appears to have resulted from violence, abuse or neglect by a person to whom they were related, were in an intimate personal relationship with, or lived in the same household (Rowlands and Cook, 2021); and National Health Service inquiries into adverse events (Ryan, 2019). This limited evidence presents a mixed picture of the potential costs and benefits of family involvement in death investigations. Family involvement can provide answers regarding the circumstances of the death, and address prevention, safety, and harm in the future (Rowlands and Cook, 2021). However, regarding Health Service investigations, Ryan (2019) highlights the emotional toll for families and critiques assumptions of 'catharsis' and 'closure'. Ryan (2019: p227) notes that performative 'participation' can easily reduce families to ancillary roles and distinguishes between vague objectives about 'lessons learned' and mobilising investigations to make demonstrable changes that prevent deaths and reassure families. Regarding fatality at work inquests, many families felt a loss of control during the inquest and rather than catharsis, sadly "many were left to blame themselves" for being unable to continue their struggle for learning after the inquest (Snell and Tombs, 2011: p216). Despite some positive inquest outcomes, investigations also risk (re)traumatising those who are already grieving. Suicide-bereaved families reported complicated and prolonged grief rather than catharsis (Spillane et al., 2019).

Limited research illustrates family experiences of (prisoner) death investigations (inter)nationally (Tomczak, 2018). Of course, families may also choose not to participate or share their experiences after enduring the investigations. Evidence comes from a mixture of grey literature (e.g. the *Harris Review on Self-inflicted Deaths in Custody of 18–24 year olds* (Harris, 2015); House of Commons Justice Committee, 2021) and a small body of qualitative scholarship (e.g. Tomczak, 2018; Easton, 2020). Regarding the experiences of families bereaved by deaths in custody, Easton (2020) found that families interpret their 'legitimate interests' in ways that differ from legal definitions, between different families and from their legal representatives including: the need for establishing truth, securing compensation or an apology, preventing deaths, providing a public record of the death, or making meaning and processing grief.

Alongside the death, the series of investigations forms a complicated, extended ordeal for bereaved families. Families "are not routinely provided with adequate information" about the investigation processes (Harris, 2015: p169). Families may be contacted by (Family Liaison) Officers representing the prison, police, PPO and Coroner. Family Liaison Officers gather information from families to contribute to investigations and, potentially conflictingly, support and inform families (Shaw and Coles, 2007). Families receive multiple reports over extended time periods, e.g. the PPO report, clinical review, pathology findings, Coroners' Prevention of Future Death report and organisational responses (Tomczak, 2018). Relatives may desire or feel obliged to participate through every stage of these processes, creating significant disruption over long periods of time. In 2007, the voluntary organisation INQUEST reported that over two-thirds of families bereaved by deaths in custody "were dissatisfied with the conduct of the inquest", spanning their treatment to "dissatisfaction with the verdict" (Shaw and Coles, 2007: p. 106). Inquest delays can run to years rather than months (Harris, 2015: p183) and dates may be set and changed several times (EHRC, 2015b), causing prolonged uncertainty. In addition to the inquest, further remedies are required

'to secure the punishment of those criminally to blame and to secure non-pecuniary damages for the bereaved' (Owen and Macdonald, 2015: 127).

The PPO bereaved families survey gathers very limited information on overall 'satisfaction' with the investigation, including communication, information, and the family liaison officer. Views are primarily collected through a Likert survey offering five options ranging from e.g., 'very satisfied' to 'very dissatisfied', thus revealing little substantive detail regarding 'satisfaction'. Moreover, the survey has a low response rate and is conducted irregularly: the PPO website[2] provides results from 2009, 2011-2013, and 2013-2015. Between April 2013 and March 2015, the PPO released 511 prisoner death reports, but obtained only 69 family survey responses (PPO, 2015). While 75% of those 69 respondents reported that the investigation had 'fully met' their expectations, that represents evidence only of 10% 'satisfaction' across all 511 reports; and 'satisfaction' rates have previously been much lower, including 50% in 2011-2013, and 33% in 2009 (PPO, 2010; 2013; 2015). These indications of 'satisfaction' vary considerably. Furthermore, it is difficult to deduce which type of death (e.g., natural, self-inflicted) garnered which level of 'satisfaction' and for whom, and it is unclear how representative the sample is across the diverse cohort of bereaved prisoners' families. INQUEST run Family Listening Days, where invited families discuss experiences and make recommendations. However, these are based on focused discussions with a limited number of participants (e.g., 9 families in INQUEST, 2018; 15 families in INQUEST, 2019) and only sample families in contact with INQUEST. We extend this evidence base, including PPO death investigators and Coroners.

[2] https://www.ppo.gov.uk/document/stakeholder-feedback/

Methods

This article reports findings from a research project running from 2019-2021. The primary research question was: how do the PPO (seek to) effect change in prisons through their death investigations, particularly for self-inflicted deaths (Tomczak and McAllister, 2021)? We report findings from semi-structured interviews with 26 stakeholders spanning three groups. Interviews elicited rich, detailed data, enabling participants to express complexities and contradictions (Bryman, 2012). In terms of the three groups, first, 16 PPO staff spanning Senior Investigator to Senior Management roles volunteered following a purposive email invitation to staff, participating face to face in December 2019. Second, nine Coroners volunteered following an email invitation to all area Coroners, participating via telephone or Microsoft Teams due to the COVID-19 pandemic in Summer 2020. Third, a bereaved relative was approached through networks and participated via Microsoft Teams in Summer 2020. All three groups were sampled purposively, as appropriate for our exploratory analysis and available resources (Bryman, 2012), but meaning that the sample is not representative of members of the three groups interviewed. All three groups make valuable contributions on their own terms, but our combination of empirical data, perspectives, and multiple observers 'adds rigor, breadth, complexity, richness, and depth' to our analysis (Denzin and Lincoln, 2000, p. 6). Family recruitment was constrained by both the resources required to gather the detail required for case-based analysis (Maruna and Matravers, 2007; Scourfield et al., 2012) and because of the sensitivity of the inquiry. Given this, the potentially stigmatising topic, the need to exclude deaths with ongoing inquests, and extensive constraints amidst COVID-19; we could not include further family participants.

Our original familial account is from Alex, whose brother took his life in prison. We supplement this with secondary data, including: the account of Stella (Tomczak, 2018) whose partner took his life in prison, reports by INQUEST (2018, 2019) and the *Harris Review* (2015). University ethical approval was obtained. All interviews were audio-recorded with participants' consent. All data

were anonymised and pseudonymised. Transcripts were thematically coded and analysed in Microsoft Word using ethnographic content analysis, which provides a systematic approach alongside flexibility to develop categories and reflect on document production (Altheider and Schneider, 2013). Ethnographic content analysis fitted the study aims of exploring how death investigations could have more impact on practice in prisons and addressed the mediated nature of data from PPO and Coroner reports. The authors worked through the documents and developed a flexible coding frame containing seven meta-themes. These included 'learning', wellbeing implications, blame and problematic narratives. Investigators' constructions of bereaved families formed an unexpected emergent theme. Anonymised interview transcripts for participants who consented to data sharing, plus supporting information, are available from the UK Data Service, subject to registration. Our analysis of practitioner perspectives can underpin future empirical research representing diverse family experiences and 'satisfaction' across overlapping death investigations, in different jurisdictions. This project requires substantive time, resources, training and reflection/debriefing, and would be influenced by the priorities of multiple stakeholders.

Findings

The value of 'fact-finding'?

Stakeholders conceptualised family involvement in death investigations differently. Beginning with families, for Alex there were two purposes: establishing the 'truth' and, 'the main purpose' of preventing deaths.

> There's two strands, […] you want to know […] what actually happened and then […] the main purpose is to stop people dying. […] The detail of the report was really important, […] it made this awful experience a little bit easier. […] While it was really difficult to read, it was really, really important […] to know actually what happened.
>
> **Alex (bereaved sister)**

Bereaved partner Stella reiterated the importance of fact finding, saying: "you need them answers" (Tomczak, 2018: p93). Coroner 4 agreed, pointing out that deaths in prison are "deaths behind closed doors" and highlighting their perception that inquests provide understanding for the bereaved:

> The family […] may not have seen their loved one for quite some time […] and then they get […] the Police turning up at the doorstep […] to say that their loved one has died. […] Everybody gets an opportunity to ask questions […], so for me the real benefit is families being able to leave Court and say: I now better understand the circumstances that led up to my loved one dying.
>
> **Coroner 4**

Ombudsmen and Coroners frequently interpreted investigations as a constructive experience for the bereaved, which does not equate to evidence of families themselves feeling 'satisfied'. Investigators stated *their* perceptions that information is cathartic for families and facilitates 'closure', which comprised 'most' of their aims:

> Most of it is to really try and give the family some kind of closure or understanding about what happened to their loved one. […] *I would like to think* it gives the family some kind of closure.
>
> **Ombudsman 10 (emphasis added)**

Another Ombudsman described multiple 'grateful' families that had benefited from difficult reading shedding light on the 'facts':

> I think it achieves a lot for the families. They get to understand […] what happened. […] I've had feedback on a number of cases where families have been really grateful for difficult reading. It's really helped them.
>
> **Ombudsman 3**

Coroners also highlighted how, when investigations go 'well', details could comfort families who might come to 'appreciate' that 'everything had been done', thus gaining reassurance and 'closure':

> When the family actually appreciate that everything had been done and their loved one had been looked after quickly and they maybe have closure at the end of the inquest.
>
> **Coroner 6**

> An inquest that goes well can bring unbelievable closure. […] Calmly and rationally go through the evidence […] and put the questions into perspective, if you do it well […], by the end you have got a family saying […]: thank you so much for everything […] and a

> Doctor saying: honestly, we really tried everything, I'm really sorry, […] I wanted to set your mind at rest. […] To watch them afterwards go out, shaking hands, […] drawing a line.
>
> **Coroner 9**

Another Coroner discussed their 'satisfaction' at 'helping people' through fact-finding:

> It is very satisfying, feeling as though you are making a contribution by helping people, so the bereaved families may come, it may be tough hearing what has happened. […] You get the sense that sometimes it helps really just to see that the matter has been investigated, it's not been swept under the carpet.
>
> **Coroner 3**

However, as Coroner 3 indicated, these details could be difficult to hear and familial 'satisfaction' was not guaranteed:

> You hope that families may get an element of closure out of Inquests, it doesn't always happen but you hope.
>
> **Coroner 1**

Investigations can reveal upsetting details about the deceased, their life, the events leading to and circumstances of their death (INQUEST, 2016: p. 86-90), which do not inevitably bring closure and indeed can be harmful. One PPO survey noted that two families "found going through the circumstances of the death too upsetting" (PPO, 2015: p. 6). However, apart from references to 'difficult reading', the potential harms and costs of investigation were rarely acknowledged by Ombudsmen or Coroners, and mitigations such as referral to support and information services for families were not explored. Moreover, it is important that investigators do not allow their own feelings or concepts of 'satisfaction' to substitute for families' lived experiences (see Gelsthorpe, 2007). Moreover, an Ombudsman highlighted training needs for those in contact with families, having on their own initiative adopted a 'straightforward' approach to communications:

> I really enjoy having contact with bereaved families. […] I've never had any training, […] I've just taken a […] straightforward approach. […] I think they want the facts, however painful […]. But, if somebody was to say: we will send you on a course […] about bereavement counselling, […] then yeah I would.
>
> **Ombudsman 12**

This raises questions about practitioner abilities to engage with diverse bereaved families. Communicating about a relative's death is highly sensitive, risking re-traumatising families and exacerbating grief (Snell and Tombs, 2011; Ngo et. al., 2018). Bereaved families might be well placed to advise on family liaison training.

Discrepancies in the details

Although families endorsed the value of information, PPO and Coronial investigations cannot be reduced to "a simple fact-finding endeavour" (Scott Bray and Martin, 2016: p. 136). Investigations always construct evidence (Scourfield et al., 2012) and perform a meaning-making function which risks individualising deaths, such that their "wider contexts […] and their full implications are negated" (Goldson, 2006: p. 57). There is also a risk that investigations are constructed to always and inevitably facilitate closure for families by providing difficult yet ultimately valuable reading, which must be problematised.

Issues arose for families when investigation details were inaccurate, patchy or delivered insensitively. Alex's family raised amendments with the PPO after receiving the draft report, which the PPO could have checked at an earlier stage to prevent loss of confidence:

> My brother's name was spelled wrong, his date of birth was wrong.
>
> **Alex (bereaved sister)**

Discrepancies between witness accounts could create or compound doubt and suspicion, as Stella explained:

> We got the statements from the PPO […] from certain officers […], we found a lot of them didn't match up. […] This is when your suspicion starts kicking in. […] It's just a natural thing […] when the doubts are there […] and things don't match up.
>
> **Stella** (bereaved partner in Tomczak, 2018: p93)

Sometimes this is resolved at inquest, when misunderstandings that emerged during the investigation may be rectified:

> The upset […] from the family […] often comes frankly from an enormous […] misunderstanding. They […] will hear bits and bobs from […] a Family Liaison Officer, or well-meaning copper. […] Obviously on their grief, rumours and suspicions […] escalate and […] may be compounded by a Toxicology or Pathology Report. […] I'm not expecting anybody would understand that off the top of their head. […] By the time they get to an Inquest, there can be real suspicion, […] hostility.
>
> **Coroner 9**

Families may believe that details have been omitted or deliberately re-narrated, e.g.: "they even lied about where he was found hanging, first it was the window then it was the bed. I knew that I had to fight them to get the truth" (Harris, 2015: p165). In bereaved partner Stella's case, errors "kept nagging on" her mind "through the two-year wait" for the inquest, where they were ultimately exposed but not resolved. Shortly before her partner's death, a bus transfer to another prison was attempted:

> On our very first meeting with the PPO that was one of my questions, […] were there any other prisoners on the bus? They said no […]. And then I asked the CID, […] he also said no. […] It never […] rung true. […] Then at the inquest two years later, it came out […] through someone's evidence that [Deceased] wasn't on the bus on his own. […] The Coroner said […] it was too late to try and find those people. […] We weren't allowed to know the names of those prisoners, that was classed as confidential. […] So in our minds that is […] four or five other prisoners that were potential witnesses.
>
> **Stella** (in Tomczak, 2018: p101)

Stella had endured this investigation over two years and participated in a gruelling "five-week inquest" that significantly disrupted her family life:

> It was every day, […] an hour journey every morning and […] I had my children [with the deceased] […], I wasn't getting home until […] 6:00, 6:30 and I was setting off before they […] left for school. So for that five-week period that was really tiring, […] mentally and physically draining.
>
> **Stella** (in Tomczak, 2018: p100)

Yet, despite Stella's endurance through the investigations, she did not get the "answers" she sought so felt without 'closure' from the unresolved fact-finding stage:

> That's all we asked, whether we liked it or not, we just wanted the truth. How can you ever have closure without all the answers? […] That that is what the inquest is for, […] you […] hope […] you are going to get your answers finally, […] to be able to move on, […] do your grieving, […] start looking forward, but it didn't work like that for us. […] We still haven't got the answers to this day.

Stella (in Tomczak, 2018: p101)

This raises questions regarding how the PPO could better prepare and signpost families to receive, understand and process draft and final investigation reports and witness statements, and how Coroners could better prepare and signpost families to receive and understand materials including Toxicology and Pathology reports. Information, context and support services for bereaved families could mitigate doubts and suspicions that could otherwise ferment and adversely affect families for long periods of time, potentially interrupting grieving and 'closure' permanently. This mitigation is particularly important because discrepancies and misunderstandings are *very likely to occur* in multistakeholder investigations into traumatic events that are investigated over months and frequently years. Indeed, S. 36 of the *Minnesota Protocol* directs that "appropriate measures should be taken to ensure" family members' "safety, physical and psychological well-being, and privacy" during an investigation (OHCHR, 2017).

Preventing deaths through investigations?

Reflecting bereaved sister Alex's words above, that "the main purpose" of investigations "is to stop people dying", bereaved partner Stella also stressed her aim to prevent deaths. Stella explained her pain after making extensive efforts to participate throughout the investigations, yet then hearing about twelve subsequent deaths in the prison where her partner died:

> I found out […] that there had been twelve other deaths since [Deceased], just in [prison name] alone and […] he had only been gone three years. […] Every one we hear about, it's like a kick in the teeth for us all over again and I think all families would tell you the same. […] That is what it is meant to be for, […] so that […] deaths can be prevented.

Stella (in Tomczak, 2018: p107)

INQUEST's reports reflected similar sentiments, highlighting that "families are seeking to make prisons safer for others" and "don't want the same thing to happen" to others (INQUEST, 2019: 27). Coroner 9 explained that the findings of prisoner death investigations could highlight repeated

systemic failures, thus eroding familial confidence in their effectiveness and resulting in emotional 'devastation':

> Their loved one's death is awful but to then realise it's based on the same systemic failures, […] again and again and again. […] The devastation caused by these families reading on the front page of PPO Reports, yet again, the same problems. […] Families […] and Coroners often feel: well, nothing has been done. […] It can feel like empty words. […] Something actually happening […] would be really important because […] the impact it has on families to find out that it's the 5th, 6th, 7th, 12th death, in the same circumstances….
>
> **Coroner 9**

These data begin to highlight the costs of family involvement (Ryan, 2019), illustrating families' frustrations at the failure of long and emotive death investigations to prevent deaths. The PPO also noted that it struggles to effect change, frequently repeating recommendations after promises of remedial action (PPO, 2019). PPO staff even considered that creating change in the Prison Service might be impossible, although it was not clear why:

> It should bring about change in the Prison Service but […] it's not always possible to do that.
>
> **Ombudsman 10**

This lack of impact from investigations is problematic, meaning that one of families' core aims may frequently not be met. The importance of mobilising findings to prevent deaths is compounded by the potential for discrepancies and distrust to emerge through investigations, as explained above. Although legal frameworks principally highlight procedural effectiveness rather than practical impacts, families' and coroners' preventative aims are supported by S. 26 of the *Minnesota Protocol* (OHCHR, 2016), which 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." Moreover, domestically in *Amin*, the core component of familial 'satisfaction' is "knowing that lessons learned […] may save the lives of others".

In theory, death investigations are learning mechanisms, but there is a risk of investigators overlooking families who want to *see changes* rather than just 'feel like a death was good for something':

> The […] public service […] idea of a Coroner […] saying: 'practical lessons must be learnt from this death' can bring a lot of learning, […] make the family feel like a death was good for something […]. I really enjoy it.
>
> **Coroner 9**

Investigators too frequently imply that a prisoner needed to die such that 'lessons could be learnt' about problems that had been repeatedly highlighted long before the fatal incident (Tomczak, 2018: p.80-81; see also Borrill et. al., 2005; Jeffs et. al., 2012). It is important that the PPO and Coroners consider the actual impacts of their investigations and are not satisfied by simply seeking to make families feel like a death was good for something.

In lieu of preventing deaths

In lieu of "demonstrable change" (Ryan, 2019: p227), investigators highlighted (their perceptions) that families appreciated modest contributions. One Ombudsman conceptualised family participation as being spoken to promptly, and having questions answered, which they had seen produce some 'satisfaction':

> As an investigator […] I have spoken to several […] families and the fact that I have taken the time to speak to them and answered their questions and responded promptly and been sincere etcetera has made a big difference to them.
>
> **Ombudsman 12**

Another Ombudsman suggested that families were satisfied by acknowledgments of their relatives' humanity through their deaths being demonstrably 'worthy' of investigation:

> Sometimes […] they ring up and thank. […] Some of them really do appreciate that we have cast light on what actually happened and […] acknowledged that the person who died was […] a human being and that their death was worthy of investigation.
>
> **Ombudsman 9**

Other Ombudsman staff acknowledged the limitations and constrained impacts of investigations, substituting a potentially comforting process for demonstrable changes:

> We would all like to change the world but […] we have to do these things incrementally, so have an opportunity at various […] smaller scales to make a difference to somebody's experience of something horribly traumatic, […] that happens more often.
>
> **Ombudsman 12**

Relatedly, Ombudsman 10 indicated that investigations could underpin further legal challenges, for families that had the emotional and financial resources to do so:

> It gives the family […] if necessary, gives them the ammunition […] to take something further and bring a case against the Prison Service.
>
> **Ombudsman 10**

The notion that death investigations could facilitate further litigation is a reminder that already prolonged prisoner death investigations are unlikely to produce 'satisfaction' for bereaved families. Moreover, if PPO investigations cannot or are highly unlikely to deliver certain outcomes (such as demonstrable changes or improved prison safety) it is important that families are made aware of that upfront, such that they can make an informed decision about whether to participate and their expectations can be better managed.

Significantly, whilst highlighting that *some* families "really do appreciate" the PPO's work, PPO staff set aside families that they considered 'unappreciative' and 'suspicious':

> Not everybody appreciates what we do, some of them are very suspicious of us and think that we are actually part of the Prison Service and […] they can't trust us at all.
>
> **Ombudsman 9**

'Suspicious' families' 'satisfaction' requires further consideration by the PPO. Legal provisions in *Letts* and S. 28 of the *Minnesota Protocol* regarding independence in perception and practice apply to all families following all prisoner deaths (see also Ranasinghe, 2015 regarding conceptualisations of the deserving and undeserving poor which legitimised claims to 'justice'). This compartmentalisation of 'suspicious' families also raises questions of equality, diversity and inclusion, as prisoners and their families have varying (protected) characteristics under the *Equality*

Act 2010 (e.g. race, ethnicity, gender and disability), which there is little evidence that the PPO or Coroners have considered.

Shaping investigations?

PPO participants indicated that families are able to influence investigation parameters:

> We always have a Family Liaison Officer, they always make contact at the very beginning with […] the bereaved family, to ask if there's any questions they want looked at.
>
> **Ombudsman 9**

However, this function is not part of the PPO's Terms of Reference (2017) and the investigation may not actually consider their questions. Families should be provided with a draft investigation report approximately 26 weeks after the death, when they can again identify questions or factual inaccuracies for correction at the Ombudsman's discretion (PPO, 2016: p10). Bereaved partner Stella compared her substantive investment in identifying questions against answers provided by the PPO. This prompts us to consider what expectations are given to families in PPO invitations to 'ask questions', highlighting the risk of tokenistic family involvement:

> The report […] took about 12 months. […] The draft […] said you could ask any questions in writing. […] So we did. We had quite a lot of questions, […] I wrote a full A4 list and [Deceased]'s sister did the same. […] And then we waited for the final copy and answers. […] Out of two A4 lists we […] got one or two questions answered. […] We felt that had been a pointless waste of time. […] I think they had just answered the ones they could and any that they couldn't, they'd just not mentioned.
>
> **Stella** (in Tomczak, 2018: p94)

Similarly, the PPO report for Sarah Reed's death at HMP Holloway noted that "Ms Reed's family had a number of questions", which included "was it appropriate for Ms Reed to be in prison or should she have been moved to a secure hospital?" (PPO, 2017b: 4). Sarah Reed "suffered from serious mental health problems" (PPO, 2017b: iii) and was remanded to prison "solely for the purpose of obtaining […] reports on her fitness to plead and stand trial" for an alleged offence (Thornton, 2017: 2). Whilst the PPO noted the family's question, their report did not engage with

it, highlight its (ir)relevance or explain whose remit it was to consider, which could be very frustrating for a grieving family, compromises the public record and misses an opportunity to create demonstrable systemic change (see also Tomczak, 2022).

Coroner 7 critiqued the PPO's practice of giving families "the opportunity to be involved" but "then just sending them the draft Report". Coroner 7 pointed out that "families feel very much side-lined" and highlighted that engagement with families is "something that they (PPO) could do much better". To improve satisfaction, Coroner 7 argued that the PPO should "explain what they can do and ultimately what they won't be able to do" in order to manage families' expectations. One Ombudsman distinguished between answers the PPO can provide and answers *that families want*. The PPO's remit and investigators' foci, although set out only in their non-statutory Terms of Reference, may not align with answers that families want:

> A family […] might have a whole string of questions that may be only peripheral to what you regard as the main issues.
>
> **Ombudsman 11**

Ombudsman 2 stated that "you try to cover as much as you can in a report" and highlighted that they would "then have to send a covering letter explaining […] why you can't investigate it". This explanatory letter appears to have not been provided for bereaved partner Stella, whose experience was described above, or perhaps investigators' practices are inconsistent. Ombudsman 9 also detailed efforts to explain to families which concerns were outside, or, dismissively, 'absolutely nothing to do with' their remit:

> Sometimes what they want looked at is absolutely nothing to do with our remit and why the person died. […] We had one yesterday where the family were very upset […] that he had been recalled to prison, (from) the community. […] They wanted that investigated but that is outside our remit so we have to explain that and look at the bits within our remit.
>
> **Ombudsman 9**

On another view, prison recall decisions and being imprisoned when acutely mentally ill (e.g., Sarah Reed) are central to 'why the person died', forming systemic hazards that produce the conditions

facilitating prison suicides (Tomczak, 2022). As such, the PPO should consider whether their current remit and practices facilitate family 'satisfaction'. It would be beneficial for the PPO to clearly outline their remit, giving examples, consistently throughout their Terms of Reference and across public and private communications, and from the earliest opportunity when engaging with bereaved families.

PPO reports become public documents, naming the deceased and detailing personal and situational circumstances leading to deaths. Families are not routinely consulted about investigators' representations of the deceased (Baker, 2019) nor entitled to amend the language, narrative, or content of the report. PPO reports use variable language; for example, publicly documenting a deceased prisoner to have "hid his true intentions" to end his life from prison staff (PPO, 2018: p.1), hence diverting the onus for suicide prevention onto dependent prisoners. As such, the PPO's use of language requires reflection.

One Ombudsman discussed potential to include pen portraits of the deceased in investigations, affording a useful opportunity for family participation (also identified by the House of Commons Select Committee, 2021: p46):

> We used to […] have a little section about the individual, how old they were, where they lived, had they any children, that sort of thing, we don't do anything like that. We are dealing with death, […] so I don't understand why we can't afford the person at least that, or the family because they [...] see the report.
>
> **Ombudsman 2**

Whilst the PPO may not have capacity to facilitate family participation in this way, it would be beneficial for this to be clearly documented in e.g., the PPO's Terms of Reference.

Balancing stakeholders

Every investigation involves multiple stakeholders, including: family members, PPO investigators, Coroners, prison staff and healthcare staff. The House of Commons Justice Committee (2021: p 15, p 26) recently advocated that families be "at the heart of the inquest process" and "feel properly involved throughout and listened to". In practice, Coroner 3 described potential conflicts between the multiple stakeholders:

> It's often said that families have to be centre stage in the Inquest process. [...] Trying to keep that at the forefront […] is important but also trying to be fair to all the witnesses. […] I don't see it as my role to have witnesses brought to Court to be humiliated by angry families and we come across a lot of angry families. […] So I have to be even handed.
>
> **Coroner 3**

As examined earlier, information and support for families at an earlier stage of the process and better management of expectations might reduce this 'anger' but would not eradicate it in all instances. Similarly, PPO reports have multiple audiences to balance:

> We have […] family, Coroner, Inquest. […] I suppose you also get Reporters because some are high profile, […] bits can end up in a newspaper.
>
> **Ombudsman 2**

Managing expectations across stakeholder groups is challenging. Different individuals and groups seek different information and outcomes:

> A Coroner and a bereaved family and (Prison) Service who […] are potentially in line for being blamed are all looking at our report from completely different perspectives.
>
> **Ombudsman 11**

These 'delicate balances' between stakeholders created tension:

> Our reports are focused on the failings rather than the successes. […] You have to think about the family […] who have lost a loved one. […] Is it appropriate to praise the Prison: they did lots of wonderful work with this person when ultimately […] they died. […] It's quite a delicate balance.
>
> **Ombudsman 13**

PPO investigations that seek to improve prison safety should give praise for good practices, which is a more powerful form of social control than blaming (Tomczak and McAllister, 2021). It would

be useful to hear directly from families about their responses to praise for staff being recorded in investigation reports and/or given informally, being mindful that preventing deaths was families' central aim.

Moreover, families are not homogeneous and individuals may disagree:

> When it is a fractured family and there are […] three individuals and […] they all want different things…
>
> **Ombudsman 2**

Whilst case law tends to invoke the next-of-kin, Ombudsman 2 indicates a broader range of familial involvement. As such, it would be valuable to consider the rhetoric of family centrality against the practicality of multiple stakeholders and difficult balances. Overpromising regarding the scope of family members that can participate and the extent of opportunities to shape investigations might be tempting when faced with grieving family members, but is likely to create problems later on and ultimately affect familial 'satisfaction'.

Conclusion

Bereaved family 'satisfaction' is an issue that cuts across death investigations globally, is prominent on various national and international law and policy agendas, and deserves sustained analysis. We have highlighted the absence of evidence illustrating the 'satisfaction' of bereaved families, addressing this by presenting primary and secondary data that highlight gaps between legal provisions 'on the books' and the experiences 'in action' of death investigators, using the case study of prisoner death investigations in England and Wales. Broadly relevant is the significant legitimising function of family involvement in death investigations despite the absence of evidence that this brings familial 'satisfaction'. Although death investigations can be deeply distressing and damaging for families in the long term (Scraton and Chadwick, 1987; Snell and Tombs, 2011; Ryan, 2019; Spillane et. al., 2019), families are regularly spoken about by death investigators and invoked

to legitimise investigations in their current form and limited impact. Our findings illustrate the need to develop a rigorous theoretical agenda to underpin family involvement in overlapping death investigations undertaken by different agencies, and an ethically produced empirical evidence base to account for varying experiences thereof.

We now indicate our contribution to this task by outlining core questions for the theoretical agenda on family participation in death investigations. This is primarily relevant to prisoner death investigations in England and Wales but has implications for other jurisdictions and across other types of death investigation, with attention to contextual differences. For each application to other jurisdictions within and beyond the Council of Europe, it will be important first to scope *who undertakes death investigations?* This may involve multiple organisations and overlapping investigations, along with their underpinning legal frameworks and evidence bases. From there, it is necessary to consider *how and when investigators liaise with families and what materials are shared with families?* The compliance of bereaved family involvement with the provisions in international guidance and relevant regional international law is the next consideration.

PPO investigators and Coroners both risked assuming that 'fact-finding' was sufficient to facilitate catharsis and closure for families. For bereaved families, understanding what happened to their relative was a necessary but insufficient outcome. Despite international guidance that family members' wellbeing should be ensured during an investigation (OHCHR, 2017: S. 36), the potential harms, costs and limitations of investigation involvement for families were little acknowledged by investigators. The core question, then, to be considered by scholars and practitioners for each type of death investigation and each investigatory body is: *what do families want from investigations? How is familial satisfaction and dissatisfaction with each of these goals (not) assessed by each investigating agency*? Assessing dissatisfaction is uncomfortable but necessary work that could facilitate improvements. Families' aims are likely to vary within and across jurisdictions, cultures,

religions and political-institutional contexts, so sensitivity and reasonable adjustments to these differences are important for investigating agencies to consider. An updated *UN Minnesota Protocol* could indicate a spectrum of families' aims and emphasise that familial 'satisfaction' through 'fact-finding' should not be assumed.

Although 'fact-finding' was important, discrepancies and misunderstandings across various forms of report and evidence were very likely to occur. There was limited acknowledgment of this by investigators and zero mitigation, which is unacceptable given the potential for discrepancies to create mistrust for the bereaved, potentially over extended time periods, and even to permanently interrupt 'closure'. The core question is: *how is familial comprehension of and confidence in the various materials that are shared with and disclosed to them facilitated and impeded?* Addressing this thoroughly could require very high investment of resources, but some contribution could also be made through freely available written, audio and visual resources that explain each country's investigations in an accessible way. Signposting families to further information and support services may also be valuable, in countries where there is any such provision. Where nothing is available, informing families of this at an early stage would at least facilitate their informed consent to participate.

Although further research is required, familial 'satisfaction' required both 'learning the truth' *and* for that knowledge to be mobilised to prevent deaths. Prisoner death investigations in their current form are not fulfilling their death prevention function. Learning about other prisoner deaths and the failures of investigations to create demonstrable changes could be devastating for families. Satisfying families and meeting legal provisions requires impacts, which investigators must engage with and not dismiss as impossible. The core question here is: *how is demonstrable impact from death investigations sought and made by each investigating body? When impact is not achieved, how are investigation practices adapted?* (Tomczak and McAllister, 2021). The importance of mobilising investigation findings to prevent deaths is only compounded by the potential for discrepancies and distrust to

emerge through investigations. In the related context of public inquiries after homicide, Peay (1996: 30) has argued that detriment to those "awaiting and undergoing the process […] can only be weighed against the effectiveness of […] conclusions and recommendations". Within assessments of effectiveness, it is also important to consider *whose opinions are mobilised and whose are discounted?*

In the absence of demonstrable impacts, investigators substituted modest contributions, such as being spoken to promptly, for the provisions outlined in law. The core question here is: *how are families informed of what investigations can and cannot consider? What evidence is there to indicate what investigations can and cannot achieve? How is this shared with families*? Indeed, Tomczak (2018, p. 109) recommends "that families have access to full, impartial information about the investigations and their potential, such that they can make an informed decision regarding if and how to participate". We do not wish to argue for any exclusion of families from death investigations in any jurisdiction, and indeed involvement can be reparative (Rowlands and Cook, 2021). However, there is a significant risk of investigations becoming performative and limited to hoping families feel like the death of their relative was in some way necessary or 'good for something'. Ambiguities in law and policies, along with expansive, unbalanced rhetoric of familial inclusion significantly exacerbate this risk. Acknowledging this risk within international guidance, such as the *UN Minnesota Protocol,* could be beneficial.

Finally, although these questions are the product of a specific case study analysis, they are relevant internationally because prisoner deaths are rising globally and (inter)national organisations are engaging with bereaved family involvement across diverse death investigations. There would be merit in exploring how (prisoner) death investigations differ in comparative context: by structure, process, governance, and outcomes. This is particularly pertinent for detention deaths given the international obligations to investigate placed upon States. To improve death investigations, both

for the families of the deceased, *and* society more broadly (Tomczak, 2021), more attention should be given to evaluating the adequacy of death investigation law, policy and practice and to identifying best practices across jurisdictions and different forms of death investigation.

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