Piers Barber Churchill Fellowship June 2025

International Perspectives on Postvention in Prison Custody

the CHURCHILL fellowship

SAMARITANS

CONTENTS

Acknowledgements and abstract	3
Chapter one: **Introduction**	4
Chapter two: **Postvention**	18
Chapter three: **Prisoners**	26
Chapter four: **Staff**	37
Chapter five: **Investigations**	45
Chapter six: **Conclusions**	53
Appendix one: **Key reading**	57

Copyright © 2025 by Piers Barber. The moral right of the author has been asserted. The views and opinions expressed in this report and its content are those of the author and not of the Churchill Fellowship or its partners, which have no responsibility or liability for any part of the report.

Cover image: 'Meeting Places' by Sandy Goanna, 80cm x 80cm, acrylic on canvas, 2025. (Boom Gate Gallery, New South Wales, Australia).

Other images: All images in this report were taken by Piers Barber unless otherwise indicate. All rights reserved. They may not be reproduced, distributed, or used without prior permission.

ACKNOWLEDGEMENTS

Thank you to the Churchill Fellowship and to Samaritans for funding this research. Thank you to everyone who discussed this difficult issue and facilitated the valuable opportunities which contributed to the findings of this report.

ABSTRACT

Postvention – a systematic process for aftercare after a suicide – is an increasingly well-developed concept, with good practice understood and roll out in community settings progressing well. Prisoners and prison staff, who frequently face a uniquely high level of suicide exposure, are particularly in need of a thorough and embedded postvention response, though relevant strategy and delivery in these settings is not yet fully developed or embedded.

This Churchill Fellowship report explores positive practice in prison postvention drawing from travel in New Zealand, Canada and Australia. It sets out how prisons should establish structured and embedded aftercare which suits different personal requirements and draws on the skills of a variety of support sources, both internal and external, procedural and pastoral, and short- and long-term. It outlines how services should aim to establish a clear culture and strategy characterised by humanity, firm leadership, suicide literacy, and joined-up partnership working to help minimise harm for all those living and working in prisons who have been impacted by suicide exposure.

More information:
https://www.churchillfellowship.org/ideas-experts/fellows-directory/piers-barber/

Chapter one:

INTRODUCTION

Contents: *About me – Churchill and prison – Prisons in England and Wales – Prison suicides in England and Wales – Clustering – Exposure to suicides in prison – Postvention – About this report – Reflections – Prisons in Australia, New Zealand and Canada – Comparisons with England and Wales*

My Churchill Fellowship examined good practice for responding to suicides in prison. Its findings are the result of travel to New Zealand, Australia and Canada combined with insights from wider experience and research.

In particular, my research explored, and this resulting report explains, how prisoners and prison staff are particularly vulnerable groups after a suicide. It sets out some ideas for how more could be done to promote recovery and prevent further incidents through the implementation of structured post-death processes.

My findings draw from conversations with academics, investigators, doctors and other healthcare professionals, policy officials, indigenous advocates, healthcare experts, charities, coroners, inspectors, and, most importantly, prison staff and senior leadership and people detained in prison. I have also read wider existing literature on this issue from these countries, England and Wales and beyond.

This introductory chapter introduces this work. It sets out background on the current situation in prisons in England and Wales and gives context on prison suicides. It introduces postvention, then gives context on prison systems and deaths in custody in the countries visited for this research.

About the author

At the time I applied for this Fellowship I led a civil service team overseeing work to prevent all forms of deaths in all places of state detention – including prisons, police custody, immigration detention and mental health detention settings – in England and Wales. Half of this work involved supporting the Independent Advisory Panel on Deaths in Custody, a panel of public appointments recruited to advise the government on the prevention of deaths.[1] The other half involved working with Government ministers and overseeing the Ministerial Board on Deaths in Custody to progress work within government and across relevant stakeholders to analyse and prevent custody deaths.[2]

I believe this experience and dual perspective means I am well positioned to draw informed and ambitious conclusions that are also realistic and aligned closely to the levers available to those who would be required to

[1] Former chair of the Independent Advisory Panel on Deaths in Custody Juliet Lyon's end of term report summarises much of the work I was involved in with the panel. See Independent Advisory Panel on Deaths in Custody, *Chair's end of term report (September 2019 - January 2023)*, February 2023 [Link].

[2] See 'Ministerial Board on Deaths in Custody' , Gov.uk [Link].

implement them. The experience of this role also means I have pre-existing insight into the impact of deaths in custody on those involved in the aftermath, including prisoners and staff but also those involved in analysing and responding to deaths several steps removed from the front line.

Prisons in England and Wales

I report on this research at a moment when prisons in England and Wales – as well as HM Prison and Probation Service (HMPPS), the agency of the Ministry of Justice responsible for custody provision – are experiencing particularly acute, and increasingly well documented, challenges.

Most dramatically, the estate faces an intensely acute capacity crisis. The prison population continues to grow, and is conservatively predicted to reach 105,000 by 2029.[3] Beyond the obvious issue – that there is currently a consistently critical lack of space to house the number of people sentenced to custody – persistent capacity challenges also have close impacts on factors relating to custody deaths. For example, they consume already highly-pressurised staff time, and make it almost impossible to locate prisoners closer to their local communities or relations or support them to productively progress through their sentence. They also make the facilitation of emotional support a low and under-resourced priority.

Sentences are lengthy and inflated. Among a host of other problems, this causes issues with prisoner hopelessness, an emotion closely associated with suicide, and the considerable aging of the prison population, with a large cohort of prisoners increasingly struggling to have their physical and mental health needs met by creaking, inappropriate infrastructure.[4]

The Covid-19 pandemic, while accelerating progress in areas such as the roll-out of in-cell telephony, predominantly set the prison service back considerably. Extremely restrictive measures put in place to prevent the spread of the disease has combined with the replacement of experienced staff with new recruits unfamiliar with running busy and active prisons to mean the restoration of regimes back to pre-pandemic levels has in places been excruciatingly slow.[5] Staff training, essential to preventing errors and building knowledge, remains considerably backlogged.

Of most relevance to this project, perhaps, is the issue of prison staffing. As all public services struggle with issues of recruitment and retention, prisons – always the least visible – have been impacted particularly severely. Simply put, staff numbers are

[3] Ministry of Justice, 'Prison Population Projections: 2024 to 2029', December 2024 [Link].

[4] Independent Advisory Panel on Deaths in Custody, *Natural deaths in prison: putting things right*, September 2020 [Link].

[5] HM Inspector of Prisons, *Annual Report 2023-24*, 10 September 2024 [Link].

currently very low.[6] Moreover, levels of staff experience and confidence have both dramatically declined. This is partly due to a decision in the early 2010s to facilitate the departure of a number of experienced staff members in austerity-driven cost-cutting measures. This was again exacerbated by the pandemic, a period which saw the further loss of experienced staff combined with the arrival of junior recruits into an operating model where prolonged lockdown, introduced in an attempt to prevent the spread of the virus, was near universal.[7]

Prison suicides in England and Wales

This complex combination of longstanding strategic challenges is likely to be increasing suicide risk: indeed, it is surprising that rates have not grown higher than their current levels. In England and Wales around 85 self-inflicted deaths take place in prison each year, a high rate of around one suicide per 1,000 prisoners. In the 12 months to December 2024, there were 342 deaths in prison custody, of which 89 deaths were what HMPPS categorise as "self-inflicted".[8] The rate of self-inflicted deaths[9] in prison is much higher than in the general population.[10]

Predominantly male, middle aged, and with a greater likelihood of having a mental health diagnosis, prisoners are already a globally significant suicide risk group.[11] This is true even before considering how this risk is magnified by the stresses, pressures and life-changing implications of prison life. The 'Joiner' theory of suicide – which posits that suicide takes place in cases of thwarted belongingness, perceived burdensomeness, and hopelessness – also explains high prison suicide rates, with all three factors clearly prevalent across all incarcerated populations. One New Zealand study, for example, found that one third of prisoners have had suicidal thoughts, with almost one in five having previously attempted suicide.[12]

Self-inflicted deaths in prison have long been a key area of concern for prison leaders, practitioners and commentators.[13] One impact of this challenge has, somewhat perversely,

[6] Russell Webster, 'Prison and probation staffing problems persist' (Summer 2024)', *Russell Webster*, August 2024 [Link].
[7] For further context, see Independent Advisory Panel on Deaths in Custody, *Written evidence submitted by the Independent Advisory Panel on Deaths in Custody to the Justice Select Committee's call for evidence on the prison operational workforce*, January 2023 [Link].
[8] HM Prison and Probation Service, *Safety In custody statistics: Deaths in Prison Custody to December 2024*, 30 January 2025 [Link].
[9] HMPPS use "'self-inflicted deaths' to refer to "any death of a person who has apparently taken his or her own life irrespective of intent". See *ibid.* These statistics, of course, do not include those who have attempted suicide or the extremely high levels of self-harm prevalent in prison.
[10] Office for National Statistics, 'Male prisoners are 3.7 times more likely to die from suicide than the public', July 2019 [Link].
[11] Discussion with Dr Jeremy Mills, Special Advisor to the Assistant Commissioner Health Services of Correctional Services Canada.
[12] New Zealand Department of Corrections, *Comorbid substance use disorders and mental health disorders among New Zealand prisoners*, June 2016, [Link].
[13] For an excellent summary, see Samaritans, *Unlocking the evidence: Understanding Suicide in Prisons*, December 2019, [Link].

been a positive advance in the understanding of prison suicide drivers and interventions. Dedicated prevention teams exist at all levels, from within individual prisons to central headquarters, and work with great dedication to prevent and analyse the causes. Extensive independent oversight exists to provide expert scrutiny and advice to key leadership.

There also exists a good knowledge of risk factors for prison suicides, which include remand status and mental illness. We also know that key sentence milestones represent moments of heightened risk.[14] There is also a reasonable understanding of how risks can be addressed, including through reducing available ligature points, increasing adequate mental health provision, and developing risk-based case management systems and monitoring.[15]

It is perhaps across a wider range of stakeholders that the problem is unknown or misunderstood. The 2023 suicide prevention strategy[16] contained limited focus on prisons, and relevant partner agencies, such as nursing[17], typically do not prioritise prison work as a prestigious vocation. As with many issues, prisons often exist separately from wider infrastructure, and are left little choice but to problem-solve alone.

Clustering

Despite these high suicide numbers and substantial challenges, the rate of self-inflicted deaths in prisons has stayed relatively stable since around 2018.[18] However, there are indications that what may be changing is where these deaths are taking place, with self-inflicted deaths tending to be less spread out across the estate and instead more focused in 'clusters' within particular establishments.

There are a range of reasons – including random chance – why this might be happening. Yet the idea that a potential contagion effect could be taking place should not be ignored. Indeed, academic research has suggested evidence of links between 'imitative suicide' and the suicide rate in prisons.[19]

Exposure to suicide in prisons

These factors – high prison suicide numbers, and a potential concentration of these deaths in clusters – mean that people in prison are therefore experiencing an *"exceptionally high"* rate of exposure to suicide and suicidal

[14] Seena Fazel et al, 'Risk factors for suicide in prisons: a systematic review and meta-analysis', *Lancet Public Health*, March 2021 [Link].
[15] *Ibid.*
[16] Department of Health and Social Care, *Suicide prevention strategy for England: 2023 to 2028*, 11 September 2023 [Link].
[17] Independent Advisory Panel on Deaths in Custody, *Natural deaths in prison: putting things right*, September 2020 [Link].
[18] HM Prison and Probation Service, *Safety In custody statistics: Deaths in Prison Custody to December 2024*, 30 January 2025 [Link].
[19] Nigel McKenzie, Michael Keane, 'Contribution of Imitative Suicide to the Suicide Rate in Prisons', *Suicide and Life Threatening Behaviour*, 31 December 2010 [Link].

behaviour.[20] Noting these dynamics as its basis, this report examines the two key resulting risk groups:

1. ***Prisoners,*** an already vulnerable population who are then permanently homed in settings where exposure to suicidal behaviour is high both in proximity and frequency. This in turn can impact their own suicidal thoughts. For example, prisoners who consult with Samaritan Listeners, a peer support mechanism which supports those at risk of suicide or self-harm (see page 16), frequently raise bereavement from suicide as a reason for them in turn also seeking help.[21]

2. ***Prison staff***, an overly pressurised workforce who experience repeat traumatic incidents which can frequently lead to burnout and resignations – a key strategic challenge for prisons worldwide.[22] Prison staff need to feel supported, safe and valued, so they can support each other and in turn provide a compassionate service to those in their care. There is convincing evidence that exposure to an inmate suicide can also produce a *"crisis of professional confidence"*, with serious subsequent implications for wider prison life.[23] Prison staff also face the longer-term issue that subsequent investigations and inquests into prison suicides can prove deeply stressful and re-traumatising.

Postvention

A programme of activities that reduces risk, minimises contagion and promotes recovery after a suicide is typically referred to as postvention. Postvention is an increasingly important element of broader suicide prevention theory and practice, though its relevance to the prison environment, especially in a context of an apparent increase in clustering, is not yet fully realised.

About this report

My research, and this report, therefore aims to profile ideas for how these two populations can be supported according to understood postvention good practice after a death in prison, particularly a suicide.[24]

The first chapter examines the theory of postvention. It summarises current understanding of good practice and outlines why delivering effective postvention in prisons is so challenging. The second draws on experiences from my travel to examine

[20] Karen Slade et al, *The impact of exposure to suicidal behaviour in institutional settings*, 2019 [Link].
[21] See Figure 3, Samaritans, *Unlocking the evidence: Understanding Suicide in Prisons*, December 2019, [Link].
[22] Penal Reform International, *Global Prison Trends 2024*, September 2024 [Link].
[23] Karen Slade et al, *The impact of exposure to suicidal behaviour in institutional settings*, 2019 [Link].
[24] Although I learned a lot about differing approaches to suicide prevention, this report focuses specifically on the aftermath of deaths.

Winston Churchill, the Home Office and penal policy

"All I can say is that there is no post under the Crown in which the holder has more need of the kindness and goodwill of his fellow men."

Winston Churchill is often quoted (and more frequently misquoted) remarking how a society can be judged according to the treatment of its prisoners. This House of Commons speech occurred during his short tenure as Home Secretary between 1910 and 1911, where his ambitious pace and high expectations resulted in an often productive creative tension with his senior officials and the Prison Commission (a precursor to today's HM Prison and Probation Service).

Today we would recognise Churchill's penal policy, which centred around a reduction of the prison population and the fostering of productive and humane conditions, as rather progressive. He championed alternatives to custody, pushed for reductions in the use of solitary confinement, and advocated for improved conditions for older prisoners and access to cultural and educational provision for all inmates.

His time in the Home Office was brief and, for a range of reasons, he was reshuffled into a new role as First Lord of the Admiralty in October 1911.

how prisoners can be supported after a suicide drawing on the pockets of good practice I encountered. The third chapter looks at equivalent support for staff. This is typically more structured and embedded into official policy than it is for prisoners, though I still found its sophistication to be limited. A fourth chapter also looks at staff support, but specifically examines how those involved in investigation and inquest processes can be appropriately supported to prevent re-traumatisation. A final chapter summarises conclusions, and a non-exhaustive list of key reading is included in an appendix.

Organisations I met with are named where relevant, though I have largely avoided naming individuals and never public officials or, of course, prisoners.

Reflections

I found the ethos of the Churchill Fellowship – to specifically identify examples of positive practice – a liberating one in the context of a topic which is understandably typically covered with focus on the most tragic of outcomes, sometimes resulting from neglectful and often malicious practice. Approaching the subject with a mindset of looking for what is being done well was revealing and is one I hope to replicate in future work in this area. Where I have referenced particular deaths, or issues with policy and practice I consider illustrative, I have not identified the prison involved, nor often the country.

A project such as this one faces a number of challenges. Prisons, and the people who work and live in them, are

rarely popular causes, and the deaths of those who have committed serious crimes are even less so. Prisons are also notoriously difficult to research. Most jurisdictions are typically highly protective of access to secure institutions, while publicly available sources such as media stories and outputs from advocacy organisations frequently dedicate focus to problems rather than areas that have gone well. And while literature on the prison officer is increasingly advanced, the prisoner experience is less thoroughly understood in formal research.

These challenges are only exacerbated when specifically studying prison suicides, and amplified yet further by looking mainly at their aftermath. It was, of course, difficult to witness first-hand how staff and prisoners responded to suicides or near misses (indeed, during one visit on an occasion when I believe one had very recently taken place, leadership were understandably reluctant to lend an overseas visitor a front row seat to what transpired).

I am also aware that the intense systemic challenges currently facing prisons in England and Wales make the findings of this report difficult to implement, and at best not a top priority. Partly for this reason, my report and its recommendations resist the temptation to call for major reviews, significant new funding streams, or the implementation of previous reports and recommendations. Such demands are largely futile. While all three would bring significant structural benefits, my objective is for findings from this work to be tangible and implementable within challenging fiscal and societal contexts.

Prison deaths, and especially prison suicides, are deeply complex and almost never caused by a single factor. Efforts from all levels of the national system to prevent these deaths are mostly impressive, led by dedicated staff, and typically hampered mainly by structural and strategic challenges that impact the effectiveness of the entire prison system. As postvention continues to grow as an area of focus in suicide prevention more broadly, I hope that this report encourages increased strategic and cultural focus on aftercare among all groups living and working in prisons who may have contact with those impacted by suicides. My intention is for this report to provide practical ideas for how this might be done.

Prisons in New Zealand, Canada and Australia

I chose to visit New Zealand, Canada and Australia to understand these issues further.

These countries have broadly similar criminal justice models to those in England and Wales. Their prisons face many of the same challenges as those at home, including widespread mental illness among the inmate population, staffing shortages, creaking infrastructure and limited capacity. All face issues with disproportionality, principally in relation to their aboriginal populations and the legacy of colonialism. Relevant for this project, these indigenous populations have

typically struggled with suicide exposure and clustering.[25] Custody deaths and suicides are key issues, though do not occur at the same frequency as they do in prisons in England and Wales.

New Zealand

Image: Tongariro Prison in New Zealand. Photo by the author.

In December 2024 New Zealand had a prison population of 10,075 people in 18 prisons[26], which are run centrally by the Department of Corrections.[27] Despite the country's low population size, a relatively high rate is imprisoned – and prison numbers are rising following a change of government in 2023.[28] I learned how prisons in New Zealand have struggled from a loss of experienced staff[29], while Covid-19 restrictions had been particularly slow to ease.[30]

The long legacy of colonialism in New Zealand means that the country's indigenous Maori population is significantly overrepresented in the prison population. While New Zealand is officially secular, the high proportion of Māori citizens in prison means that faith, religion and traditional custom are particularly relevant themes in its custodial settings. Indeed, I heard how these settings often manifest as an intensified version of wider societal dynamics and tensions in these areas.

Deaths in custody is not an insignificant issue for New Zealand authorities. When I visited, the Office of the Inspectorate had recently published a thorough review of suicide and self-harm prevention in prisons. It outlined how in a five-year period from July 2016 to June 2021 there were 29 suspected suicides in New Zealand prisons.[31] Suicide prevention in the country is largely clinical focused, with responses mostly psychology-based.

[25] I heard how many indigenous populations do not even have a word for suicide, instead using descriptors such as "died too young".
[26] New Zealand Department of Corrections, *Prison facts and statistics - December 2024*, 2024 [Link].
[27] Many of the jurisdictions I visited had chosen to structure oversight of prisons in a specific 'corrections' department. This contrasts with the British system where the majority of criminal justice functions, including the courts, are overseen by the Ministry of Justice. There are benefits and drawbacks to both models.
[28] Michael Nielson, 'Concern as prison population rises after National, Act pledge stricter sentencing amid major Corrections staff shortages', *NZ Herald*, 3 December 2023 [Link].
[29] Partly as a result of labour interchange rules which have resulted in some public sector workers, including prison officers, relocating to Australia for greater pay and benefits.
[30] Rimutaka Prison, the largest men's establishment in the country, had – remarkably – not yet reopened for social visits after Covid at the time of my trip in April 2024.
[31] Office of the Inspectorate, *Suspected Suicide and Self-harm Threat to Life Incidents in New Zealand Prisons 2016 - 2021*, September 2023 [Link].

I chose to visit New Zealand after the publication of the Department of Corrections' *Suicide Prevention and Postvention Action Plan 2022-25*, which outlined one of its key strategic focus areas to be:

> <u>*Supporting After a Suicide*</u>
> *Non-natural deaths are tragic events which have wide-ranging effects on individuals, whānau* [extended family] *and communities (including prison and community probation sites). Responses to suicide should be coordinated, culturally appropriate and humanising in nature.*
>
> *What this will look like:*
> *• Partnering with other agencies and experts who can assist…in responding effectively to suicide related events.*
> *• Standardising the approach that we…take to suicide postvention to ensure that all individuals and whānau affected are supported in a culturally appropriate and mana* [authority, status, prestige] *enhancing manner.*[32]

Some interesting wider suicide prevention and postvention initiatives exist in New Zealand. For example, I was told about one legal requirement for construction companies bidding for government funded projects to demonstrate delivery of suicide prevention training for workers as a pre-condition for approval.

I visited New Zealand in April 2024. I was grateful to the Department of Corrections for discussions on implementation of their strategy and for arranging site visits. Other highlights included spending time working with the Office for the Correctional Investigator, and a series of fascinating interviews with prison chaplains, who also supported on visits.

Organisations I spoke to included:

- Te Tari Tirohia (New Zealand Office of the Inspectorate)
- Tari o te Kaitiaki Mana Tangata (Ombudsman New Zealand)
- Chief Coroner of New Zealand
- Tira Tūhāhā Aotearoa (Prison Chaplaincy New Zealand)
- Ara Poutama Aotearoa (Department of Corrections)
- Manaaki Tāngata (Victims Support New Zealand)

<u>Australia</u>

As of June 2024 there were 44,403 adult prisoners in Australia.[33] Prisons are run at state level, making analysis of the national picture difficult.[34] State governments have differing approaches, population sizes and cohort challenges, laws, strategies and approaches to punitiveness.

From 1 July 2023 to 30 June 2024, there were 76 deaths in prison custody,

[32] New Zealand Department of Corrections, *Suicide Prevention and Postvention Action Plan 2022-25*, October 2022 [Link].

[33] Australian Bureau of Statistics, *Prisoners in Australia*, December 2024 [Link]

[34] Though some relevant services, such as mental health, are overseen nationally.

the largest number of which were in New South Wales. At least 20 of these were due to *"hanging and related complications"*.[35]

I partly chose to visit Australia given that few countries appear to have reckoned more with the issue of prison deaths in recent decades. This has specifically concerned the deaths of aboriginal prisoners, an issue which culminated in the major Royal Commission into Aboriginal Deaths in Custody, established in 1987. The implications of this review, ranging from a perceived failure to implement its findings to a resentment of the focus it has drawn away from other populations, continue to resonate.

I visited Australia in May 2024 and visited prisons in New South Wales and Victoria. Highlights included meeting the StandBy Support After Suicide team and taking part in a suicide in custody roundtable, organised by the healthcare provider Forensicare and also other health and justice colleagues. I also sat in on an inquest in Melbourne, and attended the National Suicide Prevention Conference in Adelaide, which provided a welcome opportunity to consider custodial practices and challenges within the context of the latest in wider approaches to suicide prevention. I also visited a number of prisons to speak to staff and inmates.

Organisations I spoke to included:

- Australian Capital Territory (ACT) Inspector of Correctional Services
- New South Wales (NSW) Inspector of Correctional Services
- Coroners Court of Victoria
- StandBy Support After Suicide
- ACT Corrective Services
- Forensicare
- The Hope Inside programme
- Victoria Justice Health
- Victoria Department of Health
- Corrective Services NSW

<u>Canada</u>

Image: Reading about Winston Churchill's penal reform policy next to Churchill's statue in Toronto, Canada. Photo by the author.

Canada's prisons have a federal and provincial organisational split. Unusually, this division is principally

[35] Australian Institute of Criminology, *Deaths in custody in Australia 2023–24*, 2024 [Link].

based on sentence length, with those sentenced to two years or more held in the federal system (as of January 2023 there were 12,667 people held in federal custody[36]). As well as prisons, these structural and regional variations result in different policing and court structures. I was told this can lead to a *"grass is always greener"* phenomenon, where staff in one system view the other as superior, when examining practice across jurisdictions.

Partly as a result of this structural set-up, recording and understanding precise deaths numbers, including those from suicide, is not straightforward. Rather than by a government agency, this challenge has been assumed by Tracking (In)Justice, a team of researchers who launched their innovative data set while I was visiting.[37] Key elements, for example around the cause of death, remain unknown due to data gaps. Official data indicates that across three years between 2017 and 2020, there were 23 suicides in Canadian federal custody.[38]

I visited Canada in August 2024, which overlapped with Prisoners' Justice Day (10 August), a day originating from a death in custody which is marked annually to recognise those who have died in detention. In Canada I chose to focus on the federal system, where, given the context of my work, it was more likely that people were held for a longer time and be known better to staff and other prisoners. I spent time in the cities of Toronto, Kingston and Ottawa, all in the state of Ontario where federal prisons are particularly concentrated.

Organisations I spoke to included:

- Aboriginal Legal Services
- Office of the Inspectorate
- Correctional Service Canada
- Tracking In(Justice)
- John Howard Society of Canada
- Office of the Chief Coroner for Ontario

Comparisons with England and Wales

Despite well-known challenges relating to mental health and suicide prevention, prisons in England and Wales actually have a few structural advantages and embedded systems of good practice in this area compared to the countries I visited.

In contrast to Australian and Canadian prisons, the **structure** of the system – with a central government department, the Ministry of Justice, and agency, HMPPS – is centralised, rather than regionally or organisationally fragmented. While the clustering phenomenon is of course often related to specific issues in particular geographies, this structure should, in theory, make it more straightforward to impose standards and practices and widely disseminate good practice from the 'top-down'.[39]

[36] Statista, *Average number of adults in federal correctional services in Canada in fiscal years 2001 to 2023*, March 2024 [Link].
[37] See Tracking (In)Justice [Link].
[38] Correctional Service Canada, *Annual Report on Deaths in Custody 2017/2018 to 2019/2020*, 2023 [Link].
[39] This is, of course, easier said than done, and commentators in the UK have sometimes

Further, a considerable degree of **data** about prisons in England and Wales is gathered and, importantly, made public. This is especially true in relation to deaths in custody, with datasets published quarterly and broken down by cause, demographic, sentence type, and others. A more detailed annual publication provides further deaths data breakdowns.[40] This is markedly different from the countries I visited and other jurisdictions I am aware of, and its availability and accuracy theoretically makes detailed analysis and targeting of interventions increasingly possible.

Finally, deaths in prisons in England and Wales are by policy followed by an **independent investigation**. I often heard the Prisons and Probation Ombudsman here held up as an example model by other jurisdictions, who have and continue to look to mirror or learn from its approaches.[41] PPO investigations are conducted by an independent expert team. Their results are published and, importantly, sometimes synthesised thematically.[42] I was surprised that this was not the case elsewhere.

Finally, prisons in England and Wales benefit from an unrivalled embedded system of suicide prevention **peer support** for people in prison through the Samaritans Listener programme, which importantly exists alongside medical-led intervention as means of suicide prevention.[43] The Samaritans has provided support services in

Samaritans and prison postvention

Recognising the importance and absence of strategic aftercare in prison, and building on their substantial infrastructure and impact in preventing prison suicide, the Samaritans has led the way in the development of bespoke prison postvention internationally.

Following a pilot of 15 prisons, in 2024 the Samaritans and HMPPS completed the roll-out of a programme which includes a set post-death process, training for Samaritan Listener volunteers on postvention support, and guidance for staff and prisoners on self-care and how to support others.

I understand the Samaritans' postvention offer is by far the most developed and considered formal aftercare intervention in prisons worldwide.

called for increased localism in criminal justice to improve outcomes.

[40] Conversations in New Zealand illuminated the degree to which the availability of this data is partly a result of an advanced independent prison advocacy movement in the UK.

[41] For example, see Correctional Services Canada, *Fifth Independent Review Committee on Non-natural deaths in custody that occurred between April 1st, 2017 to March 31st*, 2019 [Link].

[42] For a full list see Prisons and Probation Ombudsman, 'Learning and research documents' [Link].

[43] For many of the countries I visited, suicide prevention was principally the responsibility of healthcare services.

prisons since 1991 and their impact on suicide prevention has been significant.[44]

The ongoing development of the Samaritans programme in prison was partly what interested me in this area, as over recent years the organisation has rolled out training for Listeners to also deliver postvention interventions, with indicative signs of positive outcomes.[45]

With these potential structural advantages in mind, the next chapter outlines the theory of postvention in greater detail, explains current understanding of good practice, and sets out why its delivery in prison can be so challenging.

[44] For more about the scheme, see Samaritans, 'The Listener scheme' [Link].

[45] This was informed by a literature review and pilot evaluation carried out by Professor Karen Slade which has been of great value to this work. See Samaritans, *Pilot of Postvention Support in Prisons*, July 2020 [Link].

Chapter two:

POSTVENTION

Contents: *Introducing postvention – Good practice in postvention – The difficulties of delivering effective postvention in prison: prisoners and staff*

> *"The lifers and big timers were the ones affected most by the suicide. Women who had spent decades locked up felt as if some part of their own hope and youth had died"*[46]

Drawing from my travel experiences, this chapter summarises postvention and current understanding of good practice. It places postvention in a prison context, demonstrating the challenges faced by carceral systems in successfully implementing effective aftercare measures behind bars. It draws from engagement with prisoners and staff, as well as discussions with experts on good practice.

Introducing postvention

Research suggests up to 14 people are profoundly affected by every suicide, and that their own suicide risk is heightened by their exposure.[47] 'Postvention' refers to the provision of support following a suicide, with the objectives of supporting those impacted, reducing emotional harm, and reducing the chance of contagion.

Postvention is increasingly well understood as one of three key strands, alongside prevention and intervention, in the effort to stop suicide. In a key study from 1972, in which the term was coined, clinical psychologist Edwin Shneidman summarised both its importance and opportunity, arguing that *"postvention is prevention for the next generation"* and *"probably represents the largest problem and presents the greatest area for potential aid."*[48]

Focus on postvention is increasing. For example, it is a fairly prominent part of our national suicide prevention strategy.[49] It has probably received its most prominent public coverage in the context of suicide clusters of university students, which have resulted in thorough and specific response guidance and interventions.[50]

My conversations with experts reinforced the idea that preventing contagion, or repeat incidents, should not be the sole objective and only

[46] Jennifer Toon, 'Mourning a Stranger's Suicide inn Prison', *Marshall Project*, August 2019 [Link].
[47] Jordan, JR and McIntosh, JL (eds.), 'Suicide bereavement: Why study survivors of suicide loss?', *Grief after suicide: Understanding the consequences and caring for the survivors*, 2011, pp. 3–17.
[48] 1972 Edwin Shneidman quoted in FR Campbell, 'Changing the legacy of suicide', *Suicide and Life Threatening Behaviour*, 1997 [Link].
[49] Department of Health and Social Care, *Suicide prevention strategy for England: 2023 to 2028*, September 2023 [Link].
[50] See, for example, Sally Weale, 'Suicide is a sector-wide issue, says Bristol university vice-chancellor', *Guardian*, 21 February 2018 [Link].

success measure of an effective postvention response. Exposure on its own does not equate to trauma, let alone suicidal ideation or attempts. Equally, contagion impacts do not mean that a postvention response has been ineffective. Instead, tests should also include whether people felt supported, if they felt they had a voice in shaping that support, and whether they were retraumatised.

Good practice in postvention

I spoke with a range of postvention experts who shared perspectives and consensus on good practice.

Postvention: good practice

- Postvention should be embedded within organisational strategy and culture. It is important that aftercare responses are methodically integrated into typical operating patterns and organisational values so procedures and expectations are clearly understood. Responses should be planned, organised and reliable. Leadership has a key role in role modelling, championing and evolving aftercare responses.
- Postvention should include an element of clinical supervision. Medical checks and subsequent relevant interventions can have important and sometimes essential positive impacts following an incident.
- Support should be multi-agency. Despite its importance, support following a suicide should not come solely in the form of a medical response. All individuals and organisations who have contact points with those impacted can play important roles depending on the individual's preferences. Aftercare should be responsive to the individual affected, who is the most reliable expert on how they can stay safe.
- People should have access to both internal and external support sources. Internal support offers those impacted the opportunity to engage with people they trust, who may have a greater understanding of their triggers and behaviours and be more perceptive to longer-term indicators. Yet external support can identify issues which would otherwise be missed, and people impacted often feel reluctant to 'burden' those who they are close to. External support also means that the emotional load is not placed on internal responders, who themselves may have been closely involved in and impacted by an incident.
- Responses should prioritise the development of suicide literacy. This helps everyone in a system to understand triggers and risk factors and

how these might manifest. Understanding presentations, and validating these, is an important element of effective postvention.

- Support should be available to mitigate both short and long-term impacts. The effects of an incident can emerge and develop over many months. People can require different support at different moments – indeed, the most profound impacts may manifest weeks, months or even years after the original incident.
- Peer support can play an important role. People are often most receptive to and appreciative of advice or support from those with a similar lived experience to their own.
- Support should be proactive. As with all forms of suicide prevention, those impacted mostly do not want to feel like a 'burden'. Support should, as much as possible, be visible, accessible and forward-thinking.

Aftercare is difficult to evaluate, though there are ways that interventions can be assessed through tests such as wellbeing surveys, self-assessment tools and staff attendance and attrition.

The difficulties of delivering effective postvention in prison

It is clear that their unique level of exposure to suicidal behaviour means that prisoners and staff should be considered among the most significant risk groups for suicide contagion and a key recipient of thorough postvention support. In some ways, delivering postvention in prisons should be more straightforward than elsewhere, not least because those affected are always in a specific, known location, meaning follow-up should be more programmable and access easier.

Yet delivering effective postvention in closed settings is extremely difficult. To begin with, good practice in postvention prioritises coordinated, multi-agency support from all relevant parties – a notoriously difficult task in prisons where relationships, information sharing and ways of working between different teams and agencies can frequently range from fragmented at best to hostile at worst.

My Fellowship research also shed light on other group-specific reasons that make prisons especially difficult environments to deliver good practice in postvention.

Prisoners

- Prior instances
- Secrecy
- Communication skills
- Risk aversion
- Geographical factors
- Prisoner movement
- Pace and stress
- Information flows

Family, health and lifestyle factors mean prisoners are more likely to have been exposed to **prior instances of suicidal behaviour** and other traumatic incidents in their lives, including those relating to bereavement.[51] Trauma exists in a range of forms, including historic, personal and cultural, all of which can be individually or cumulatively present among people in prison.[52] Prisoners are therefore at a greater risk of being impacted by suicidal behaviour. This means it is more likely for a suicide to be one that cumulatively contributes to the emotional burden of previous events, therefore requiring timely and expert management and untangling.

Prisons are typically highly **secretive** communities. Prisoners typically do not want to appear to be 'weak' or a 'burden' by seeking help.[53] Officers can often be wary of getting too close to those who they must retain a position of authority over. When discussing suicide aftercare, prisoners I spoke to referenced specifically how they felt authoritarian staff did not solicit the sort of trusting relationships which would enable them to feel comfortable sharing information about prior trauma or evolving, complex emotions. This dynamic often combines with staff attitudes of cynicism to undermine a culture of prevention.

On other occasions, prisoners are afraid that raising concerns relating to suicide will put them at risk of punishment. Indeed, one New Zealand study has suggested male prisoners are less likely to seek help for suicidal feelings than for other more general personal problems partly due to treatment concerns.[54] In countries with more extreme, restriction-based approaches to responding to suicide risk, prisoners were concerned that raising concerns would result in being placed in isolation.

Prisoners typically lack the sophisticated **communication skills** it can require to articulate the impact of a suicide. This is sometimes due to higher rates of neurodiversity, lower levels of education and mistrust among typical prison populations – or a complex combination of all three. This means many prisoners are less adept at communicating their emotions or calmly or proactively requesting help. This is a particular risk where consultations with time poor medical staff often rely heavily on accurate and forthcoming self-reporting and presentation.

Prisons are typically **risk averse** settings. New approaches can be resisted and mistrusted. Rather than prioritising effective contact with those in their care, I heard how staff often

[51] For more on bereavement in prison, see Nina Vaswani, 'Bereavement among young men in prison', *Criminal Justice Matters*, November 2014.

[52] This was persuasively explained to me by Dr Chris Bowden, an expert in postvention from New Zealand.

[53] Seena Fazel et al, 'Risk factors for suicide in prisons: a systematic review and meta-analysis', *Lancet Public Health*, March 2021 [Link].

[54] Skogstad P, Deane, FP and Spicer, J, 'Barriers to Helpseeking Among New Zealand Prison Inmates', *Journal of Offender Rehabilitation*, 2005 [Link].

respond to serious incidents by locking down wings or wider areas. This is understandable in settings which must always prioritise security, though such an approach can have negative impacts on recovery for those impacted by a suicidal incident. This issue is illuminated further by research which has frequently demonstrated the importance of not being alarmist in response to suicidal thoughts.[55] More practically, prison staff are frequently overworked and time poor, especially in the aftermath of a death where policy, processes (such as police and family liaison) and management of their own emotions (see below) can reduce their physical and mental capacity to support other prisoners.

A range of **geographical factors** also both amplify the postvention need in prison and make good practice in delivery a challenge. Simply put, the closed nature of prisons means that if a suicide incident occurs, other prisoners are inevitably very physically close to it. This means that more people are exposed to the incident, at greater proximity and for a longer duration than is typically the case for such deaths elsewhere.

Prison geographies also poses difficult combinations of intense isolation, restricted movement, and a complete lack of private space. This makes enabling access to support very difficult – be that internal sources, such as peer workers, who frequently struggle to get permission to attend someone in need or identify a place for private discussion, or external sources, who may be daunted or prohibited by the closed nature of prisons.

Alongside this, **prisoners move frequently**, especially those on remand or at the start of their sentence. Such cohorts are commonly understood to be those among the highest risk of suicide.[56] This makes it difficult to build understanding of triggers and establish trusted relationships and support networks. Provision of anything resembling considered, long-term support is therefore very difficult.

In many ways, prisons are **fast-paced and eventful environments**, where the ambition to effectively respond to a single incident which might typically elicit significant resources in the community is frequently undermined by new, similarly complex and serious incidents taking place shortly, often just hours, afterwards. This makes providing appropriate support for prisoners highly complex and operationally difficult.

Finally, **information flows** are notoriously difficult in prison – be that information about an individual's risk factors or the dissemination of learning from deaths to staff. This makes the management and identification of postvention support needs and its subsequent delivery a considerable challenge.

[55] Talk by Associate Professor Laura Shannonhouse, George State University, at the 2024 National Suicide Prevention Conference, Adelaide, Australia.

[56] See chapter one.

Staff

- Prison culture
- Accessibility
- Multiple psychological hazards
- Geographical factors
- Operational realities

As with prisoners, research has demonstrated that prison staff are themselves at a higher risk of suicidal thoughts and behaviours compared to the general public.[57] Staff reactions to a prisoner suicide can be highly complex, with emotions ranging from anger to guilt to, in cases where prisoner-staff relationships are developed, intense sadness.

Prison culture poses challenges to providing adequate aftercare support for staff. Officers have a typically **secretive, 'macho' and self-protective culture**. Staff often want to be considered tough in front of their peers, and are conscious of censure in a world where blame culture can be common. Cynicism about prisoners is often deeply embedded. Officers have to manage their reactions and presentation to prisoners, always needing to be conscious of a need to achieve a delicate reputation of authority and distance. Staff are particularly conscious of this after a serious incident.[58]

It is also notoriously **difficult to reach** staff with messaging, policy changes or information about sources of support. Reasons for this are often practical: a lack of time or ability to access staff intranets, for example. This is amplified in some jurisdictions by staffing shortages which have resulted in the increased employment of overseas staff, with resulting language and communication challenges.

As with prisoners, it is not uncommon for prison staff to be exposed to repeated serious incidents, often referred to as "**multiple psychosocial hazards**", in a single day.[59] This makes adequate processing of a particular incident highly challenging and adrenaline-based responses common. Shorter- and longer-term reactions are variable and unpredictable depending on the individual. Indeed, WorkSafe Victoria, an Australian programme, actively warns against the consideration of individual psychosocial hazards in isolation given the impact of concurrent and cumulative events.[60] This is a complex area to navigate. In community cases such circumstances are often addressed through external support provision, with the reasoning that it is important that the burden of supporting colleagues through an incident is not placed on a team that will also be personally affected. But this

[57] Matthew S Johnston and Rosemary Ricciardelli, 'Documenting the mental health climate in correctional work and the realities of suicide', *Frontiers in Psychology*, January 2023 [Link].
[58] Colette Barry, '"You just get on with the job": Prison officers' experiences of deaths in custody in the Irish Prison Service', *Prison Service Journal*, 2017 [Link].
[59] Cultural Review of the Adult Custodial Corrections System, *Safer Prisons, Safer People, Safer Communities*, December 2022 [Link].
[60] *Ibid.*

is culturally and practically difficult to facilitate in a prison environment.

Although free to leave the site at the end of the day, **geographical challenges** also pose challenges to delivering effective postvention for prison staff. Firstly, they face consistent exposure to the same cramped, closed location, and will indeed often be required to inspect or deliver wider work duties in a cell where they may have previously been involved in responding to a traumatic incident. Geographically prisons are also often located in highly isolated areas, where feelings of loneliness and of being forgotten can be enhanced and the facilitation of external support challenging. This compounds issues around self-esteem among a staff group which often already feels hidden and undervalued as a public sector workforce.

Operational realities also pose challenges. Time and space for emotional processing is limited. Unlike other settings where a suicide may occur, prisons must remain operational and secure at all times. Longer-term, prison processes are notoriously, and to a great extent rightly, thorough and process-driven. Responding to an incident in a way that meets often justifiable prison and wider public sector expectations takes time. In the context of deaths in custody, this involves a complex combination of internal and independent investigation processes, with timelines completely outside the control of the staff involved in the original incident. In addition, such processes involve high levels of scrutiny, and can be high profile and deeply critical. In the context of postvention, they mean pain can be prolonged and the risk of re-traumatisation severely enhanced.

Conclusions

Postvention must form a central part of all suicide prevention efforts. In the case of prisons, prisoners and staff represent two significantly at-risk populations that are structurally, physically and emotionally hard to reach with best practice support.

Chapter three:

PRISONERS

Contents: *Immediate management – Notification – Staff support: a "dose of sincere connection" – Spiritual practice – Ceremony – Suicide literacy – External support – Technology – Peer support – Leadership, strategic coordination and mapping – Deaths on the outside – Scrutiny bodies*

> *"You always sense that it will add to another prisoner's despair, so they need a lot more support at this time. [It] casts a dark cloud over other prisoners."*[61]

This chapter summarises reflections on support that can be provided to prisoners exposed to a suicide or suicidal behaviour. I identified a number of positive practice examples from my travel, though these were often inconsistent because of either impracticalities or the absence of a consolidated, multi-agency strategy.

Despite this, good ideas and pockets of commendable practice were both possible to identify in a number of sites and set-ups. This was more often than not a result of compassionate and brave individuals, especially from those in leadership positions. This is also a common feature when examining good practice in wider community postvention.

Immediate management

The proximity of other prisoners to a suicide makes the immediate aftermath of a death particularly risky from a postvention perspective. Effective initial management of an incident is therefore vital to mitigate potentially harmful impacts.

Staff at the prisons I visited typically explained how tents and cell window covers are used when a body is visible by other prisoners on a wing. Often, though, this can heighten distress as much as mitigate it.

Coroners in New Zealand told me that the country is thought to have some of the quickest initial post-death processes worldwide, principally due to the requirement of Māori customs that a body must be 'processed' within 48 hours. The context of this cultural requirement typically means that the initial steps are taken commendably promptly.

In Canada I heard about challenges posed by long waiting times for the arrival of medics or a coroner to declare a death. I was told nurses will soon be permitted to perform this function, therefore reducing wait times and the perception among inmates that sufficiently prompt action is not being taken.

Notification

Clear communication in prison brings transparency and produces confidence

[61] HM Inspectorate of Prisons for Scotland, *Independent Review of the Response to Deaths in Prison Custody*, November 2021 [Link].

and trust in leadership and staff.[62] As part of work to assess the viability of their own prison postvention process, Samaritans focus groups highlighted the importance of *"sensitive and clear information about the death"*, noting the link between notification and suicidal ideation.[63]

I visited prisons that shared the news of a suicide clearly and officially, rather than allowing news to spread by word of mouth. This is a nuanced issue, with inappropriate notification sometimes increasing risk. Generally, though, prisoners I spoke to said that receiving formal acknowledgement of a death helped them with starting to process it. News should be delivered in a timely manner. Verbal, in person notification delivered by staff who have been supported on how to sensitively break such news is likely to be most effective. Other methods can also still be appropriate. One prison in Australia, for example, provided notification via a prisoner email service, formally acknowledging the death while also using the correspondence to flag available sources of support.

In contrast, other prisons I visited did not share official news of a suicide, risking the escalation of conjecture and typically indicating the absence of structured aftercare for those exposed to the second-hand news. Other jurisdictions had specific criteria about who should be informed. While there is logic to limiting exposure to the news to, for example, those who lived with the deceased or directly witnessed the incident, such attempts can backfire in settings where rumours spread rapidly and sensitivity to such events can be so triggering, impactful and unpredictable.

Leadership must take responsibility in this area, ensuring their staff are trained to deliver such news and challenging those who do not, or do not do so appropriately.

Medical checks

Healthcare checks for some prisoners after a serious incident appeared to be fairly routine across the prison systems I visited. These should be prioritised for those identified to be at greatest risk. For example, in Canada I heard how initial focus particularly falls on those who had previously declared suicidal ideation during initial induction and other ongoing screening processes.

At the same time, sites must apply a broad understanding of who may be affected by a suicide beyond those immediately exposed. To this end, I heard how healthcare checks in Canada were offered to everyone and also included the option for people to change their mind about subsequently engaging later.

Staff support: a "dose of sincere connection"

[62] HM Inspector of Prisons, *Improving behaviour in prisons: A thematic review by HM Chief Inspector of Prisons*, April 2024 [Link].

[63] Samaritans, *Pilot of Postvention Support in Prisons*, July 2020 [Link].

Effective aftercare responses need to balance policy interventions – such as suicide case management monitoring and medical consultations – alongside a need to deliver basic human companionship to vulnerable people. As one expert summarised, *"distress is distress"*, and people typically want, and need, something more than a process-driven medical response.

At the Australian National Suicide Prevention Conference, I heard Professor Laura Shannonhouse outline how her work on suicide prevention among older people had demonstrated how just a *"dose of sincere connection"* – not counselling or therapy but just genuine human interaction – demonstrated signs of positive outcomes.[64]

In prison, the typically authoritarian character of staff relations with prisoners make this particularly challenging. One prisoner explained how support after one incident had been process-based and purely transactional: instead they had wanted staff to *"put away the binders"*, and to be treated less as patients and more as individuals as part of a community. He told me people needed to be made *"OK to feel"*, and suggested that staff facilitate the running of support groups led by those with lived experience to support the prisoner community after a death.

More positively, other prisoners I spoke to highlighted specific members of staff who had provided empathetic support in the aftermath of a suicide. It makes postvention yet another lens through which to examine the importance of effective and compassionate staff-prisoner relationships.

Spiritual practice

I held a number of fascinating interviews with prison chaplains in New Zealand, where the disproportionately high Māori prison population makes it especially important that the aftermath of a death is managed in a culturally sensitive way.

This role of New Zealand prison chaplains in responding to a death in custody appeared to be more advanced, with the position more deeply embedded, than in other jurisdictions I have encountered. This was reinforced by policy and guidance documentation explaining the intricacies of this process that was shared and discussed with me.

Chaplains are a key part of the protocol for a critical incident response. When this works well, I heard how a chaplain is called immediately, at any time of the day, to attend following an incident. In the immediate aftermath, their roles include conducting an initial and closing prayer, overseeing the clean-up, ensuring bedding is destroyed, and blessing the cell and body.

They ensure that processes take place quickly and that nobody is put in the

[64] Talk by Associate Professor Laura Shannonhouse, George State University, at the 2024 National Suicide Prevention Conference, Adelaide.

relevant cell until three days have passed. They will also spend time praying with those in nearby cells. Slightly later, they will address prisoners about the incident, in a hall or loudly on the wing. They will often do a service for those in the unit, where other prisoners will be invited to speak and where family members are sometimes invited to attend. On occasion they will support dedicated services with local elders, and chair discussions reflecting on the life of the deceased.

Such culturally appropriate rituals are seen as important steps towards closure for other prisoners. In addition, prisoners can take comfort from access to a chaplain. Although based in the institution, I heard how they often view their relationship with a chaplain as distinct to those with uniformed staff, and therefore less likely to be characterised by mistrust and complex authoritarian dynamics.

Chaplains, as established figures in the institution, also have informal roles providing support to staff, be that through praying with first responders or explaining practice to younger officers.

The success of this role appeared to depend partly on two factors: firstly, the complex embedded role of spirituality in day-to-day life[65]; and secondly, the effectiveness of individual chaplains, including the degree to which their role is embedded, embraced and understood by senior management. Effective chaplains are able to 'muscle in', persuasively insert themselves into relevant situations, and establish productive ways of working with Kaiwhakamana [Maori community representatives] and iwi [tribes]. The experience and trust of leadership is key. For example, some senior managers will contact their chaplains immediately, while their counterparts in other institutions may have less of a role where such trusting relationships are absent. When well embedded, chaplains told me they are able to deliver services even when space was tight or security high, and importantly felt that deaths were managed appropriately.

Chaplains sometimes have an important long-term role to play, too. They are individuals embedded into a particular site and have established relationships with prisoners, while at the same time are not affected to such a degree by the same burden of mistrust as uniformed officers. They may also have a more perceptive and intricate understanding of a prisoner's behaviours and triggers, and can play an important role in intervening to prevent longer-term support from falling away for those who need it.

Spiritual leaders or aboriginal representatives also had roles in the prisons I visited in Australia and Canada. Staff I met also talked positively about their role, though often

[65] Section 79 of the Corrections Act (2004) says that prisoners in New Zealand must have access to spiritual support.

referenced movement restrictions in high-security settings which undermined the lengths to which they could go to provide support.

Ceremony

Processes overseen by the prison chaplains I met in New Zealand are an example of the importance of ceremony as a vehicle for processing an incident and moving towards closure.

> A New Zealand prison I visited explained an example of a "gold standard" post-death ceremony. The body was brought out of the cell and held in a larger meeting space, in this case the gym. Prisoners performed a haka [dance] and waita [song] as the body was removed. Other prisoners were unlocked and permitted to walk past the body to pay respects. This was followed by a lunch where the deceased was discussed and memories shared, with the whole process attended by local village elders.

Justifiable efforts to accommodate relevant cultural practices have no doubt increased the frequency of such interventions in the post-death processes of the three countries I visited compared to England and Wales. These typically took the form of blessings, smoking ceremonies and visits by community elders.

Such ceremonies are not straightforward in prison, involving as they do the movement and gathering of many individuals[66], and policy documents I saw frequently provided Governors (or their equivalents) with discretion over their appropriateness. This leads to inevitable local variations in their usage and again places emphasis on the importance of leadership in ensuring effective aftercare.

Ceremonies can also be facilitated in other forms. One prison in Australia permitted and enabled the live-streaming of funerals of relatives on the outside for those not granted permission to attend in person, with similarly useful benefits from the perspective of postvention.

Grassroots memorialisation efforts and activism also play an important role in comforting prisoners who have experienced an inmate suicide, as well as families and relatives outside. My visit to Canada coincided with Prisoners' Justice Day, an annual occasion to pay tribute to those who have died in detention. As well as public events[67], such as rallies and university talks, this annual event is also marked within prison walls. Its facilitation by staff can only help with the grieving process.[68]

[66] And, in the case of smoking ceremonies, some very genuine fire safety risks.

[67] The day also provides a "hook" for initiatives relating to the prevention of deaths in custody, with the 2024 iteration marked by the launch of the Tracking (In)Justice data initiative discussed in the Introduction.

[68] In contrast, the break-up of prisoner memorials by authorities, which took place on

Less structured remembrance processes can also play an important role. As one study concludes: *"exploration of narrative and 'story-telling' approaches to bereavement may prove promising in encouraging participation in interventions and in improving outcomes for a vulnerable and troubled group of young men."*[69]

Suicide literacy

Taking proactive steps to promote knowledge and awareness of how someone might react to a suicide is vitally important in validating their emotions. I heard how this was a challenge in Australia where particularly Pacific Islanders do not have a culture of speaking about suicide. In contrast, I visited a prison in Canada where inmates were taught how to spot suicidal behaviour in others as part of their induction process, awareness which can be life-saving in the event of an incident.

External support

Even with compassionate, suicide literate staff and the availability of comparatively well trusted figures such as chaplains, prison dynamics and culture mean that inmates are still frequently unlikely to feel capable or willing to disclose their emotions to internal support sources. The availability of relevant external and independent resources may therefore have an important role to play in prison aftercare.

StandBy is an Australian nationwide community and non-clinical service which provides practical and direct support to those impacted by suicide. Those impacted by a death contact the service, which delivers personalised support, normalises suicide reactions, signposts resources and, where relevant, provides referrals to relevant services. Its work across communities is seen by experts as exemplary in the postvention field.

In New South Wales, I learned how the service is testing the model's applicability for prisoners bereaved by suicide. I heard how initial iterations have involved coroners notifying the service of prison deaths, with employees then visiting the establishment to meet with relevant prisoners to support them with the processing of an incident.

Such a model makes good sense when considered alongside positive practice in community postvention, as well as some of the challenges faced in reaching prisoners with support, namely authoritarian relations with uniformed staff which can prevent honest personal sharing of emotions and struggles.

StandBy places a high importance on explaining potential reactions to a suicide and outlining how people can

---

one occasion on my trip, can have damaging retraumatising effects.

[69] Nina Vaswani, 'Bereavement among young men in prison', *Criminal Justice Matters*, November 2014.

expect to feel or react, such as forgetfulness or a fear that someone is 'losing their mind'. This also includes how reactions develop, reappear or initially emerge over time. Typical prisoner backgrounds often mean they are particularly unaware of these potential impacts, making such an intervention especially valuable.

In addition, the service provides an opportunity for people to offload to someone with whom they do not have an ongoing, authority-based relationship, such as a staff member, or be conscious of retraumatising another, such as a fellow prisoner. An independent figure can also provide an outlet within a culture where secrecy, and concern about being perceived as either having a 'weakness' or being a 'burden' are both commonplace. As independent support, such interventions are also not accountable to the prison or part of a corporate structure which could have been at fault for the original incident.

Despite such advantages, there are also clear challenges posed by such a model, which also serve to illuminate the challenges faced by attempts to deliver effective postvention in prison. For one, prisoner movement is transient and unpredictable, making it challenging to provide any sort of medium-term, let alone long-term, support, especially in remand or local prisons. There are also cultural challenges to overcome, particularly how to encourage staff to facilitate and buy-in to the mission of the service.

Partly for this reason, such services appear currently largely dependent on the persistence and dedication of specific staff, as well as the strength of personal relationships they are able to establish with host institutions. Finally, the complex prior trauma of prisoners, not uncommonly involving exposure to other suicides, makes it difficult and indeed potentially dangerous to attempt thorough individual support in short, isolated doses. Still, there is clearly high potential value in considering this model and its broader applicability for different jurisdictions.

Peer support

The successes of the Samaritans' Listener programme in prisons in England and Wales has demonstrated the impact and cost-effectiveness of structured or semi-structured peer support in suicide prevention. It would follow that such initiatives, especially where relevant cultures and infrastructures are already in place, can also have an important role to play in suicide aftercare.[70] As argued by HM Inspector of Prisons, *"the quality of the peer work scheme in a prison is often indicative of the prevailing culture"*, serving as indication of where *"leaders*

[70] Some have expressed concerns about the unintentional harms of peer support initiatives on those who volunteer. While I understand these arguments, they should not detract from the positive experiences of the majority of volunteers, not to mention the considerable beneficial impact they have had on those they support. See Gillian Buck et al, 'Prisoners on prisons: Experiences of peer-delivered suicide prevention work', *Incarceration*, May 2023 [Link].

and prisoners have worked together to establish a well-functioning community", an atmosphere which can only positively impact its inhabitants in the aftermath of a serious incident.[71] Ultimately peer workers can provide those doses of *"sincere connection"* which can make the key difference.

Peer support models in the countries I visited were not as developed as those in England and Wales. In Australia I met a group of prisoners with a role in providing support to other prisoners after a death, which was of clear benefit to both parties. Those I spoke to felt they had a role to play in post-death support, principally due to their shared experiences and ability to identify with the emotions of those impacted. However, they smartly identified the risk of being forced into playing an inappropriately prominent role in the process of responding to deeply complex incidents, or, at worst, being used by uniformed staff and leadership to absolve their own responsibilities.[72]

Long-term support

It is well understood that reactions to a suicide can develop and change over time. An individual who may not be impacted at all initially may develop reactions which can impact their own safety months and even years after an event. Experienced staff explained to me how it was important for wing and healthcare staff where possible to build knowledge of a prisoner and their triggers to be able to notice and react to behaviour changes. Such support – be it from staff, peers or external parties – also needs to strive to be proactive and not reliant on self-advocacy from inmates themselves.

Leadership, strategic coordination and mapping

Findings from this chapter ultimately demonstrate the importance of optionality and accessibility in postvention for prisoners. Yet all the interventions set out so far are also clearly dependent on leadership to be initiated, embedded and promoted.

Firstly, leaders must advocate for and promote the provision of compassionate postvention support, and provide firm challenge in instances where staff do not deliver expected practice. Leaders have a key role in articulating that postvention is not the job of 'someone else'. The work of academics such as Chris Bowden in New Zealand, who I met on my trip, highlights the vital importance of leadership in accepting the necessity of postvention, especially in welcoming the benefits and potential challenges that come from external input.

Secondly, postvention needs organised, strategic coordination to avoid people 'falling through the cracks' of various support provisions. When a range of interventions exist, this also poses the risk of individual practitioners

[71] HM Inspectorate of Prisons, *Improving behaviour in prisons A thematic review by HM Chief Inspector of Prisons*, April 2024 [Link].

[72] They can also find themselves unfairly held to higher behavioural standards.

absolving responsibility. This is a consistent challenge in prison: psychiatrists I met in one establishment, for example, told me about the difficulties in ensuring joined-up support across a patchwork of public and private healthcare providers and prison staff which meant potential support touchpoints with those needing support were missed or passed over.

There are clear benefits for all involved in striving for clear multi-agency coordination. I heard about policing initiatives in Western Australia where a comprehensive mapping exercise of touchpoints for all relevant parties with an individual impacted by a suicide had helped identify where engagement moments had previously been missed and where support sources could have been flagged.[73] Such an approach should be taken in prisons to ensure all relevant parties have a firm understanding of the specific roles they can play in supporting prisoners after a death at different moments.

Scrutiny bodies

Finally, inspectorate and investigatory bodies have an important role to play in analysing good practice in post-death processes. To start with, of course, examining deaths in custody should be a key focus area in inspectorate methodology and thematic focus. The Office of the Inspectorate's extensive thematic review into suicide and self-harm in custody in New Zealand, published just before I arrived in the country, was an exemplary example of this.[74] Inspectorates should ensure they are examining postvention and aftercare as part of this analysis, as achieved by the Office's perceptive specific chapter on the issue.

Image: Report into the death of a male detainee at the Alexander Maconochie Centre, Australian Capital Territory[75]

Support for detainees

Detainees were advised of the death via email from the General Manager the following afternoon. In this email, detainees were encouraged to seek support through Chaplaincy, custodial staff, CMH or PH staff, or Lifeline (available as a free call number from unit telephones – accessible for timed 10 minute calls when detainees are not locked in although the phones have limited privacy from detainees who may walk past).

In the days following the death, members of the SCIT checked in with a number of detainees who were accommodated in the MU on the night of the death, and also other detainees with known vulnerabilities. SCIT also emailed all detainees offering support and providing a variety of means to get in touch with the team. OICS understands that very few detainees sought out support in response to this email. It is noted that Detainee A was a new arrival, had not been housed in an accommodation unit, had only had a brief previous period of incarceration and therefore may not have been known to many other detainees.

OICS notes that efforts were made by ACTCS, particularly the SCIT to offer support to detainees in the wake of the death in custody. Notwithstanding this, when OICS was onsite at AMC for reasons not related to this review, a number of detainees unprompted raised concerns that the death in custody left them and other detainees feeling unnerved and they felt they had no easily accessible mental health / counselling support. In these discussions detainees often also referred to their more general concerns about the lack of sub-acute mental health support and counselling at AMC including for depression and anxiety, as well as their concerns about the austere environment of the MU as a COVID-19 isolation unit on induction (discussed further in section 7.2 of this report).

[73] Talk at 2024 National Suicide Prevention Conference, Adelaide.
[74] Office of the Inspectorate, 'Postvention: after a suspected suicide', *Suspected Suicide and Self-harm Threat to Life Incidents in New Zealand Prisons 2016 - 2021*, September 2023 (pp. 111-115) [Link].
[75] ACT Inspector of Correctional Services, *Death in custody at the Alexander Maconochie Centre on 1 February 2022*, 2022 [Link].

Investigation bodies should also have a clear role within their terms of reference to examine whether aftercare was delivered, and if so, how effectively. This should include, and indeed prioritise, examples of good practice and where responses have been managed effectively. The Australian Capital Territory (ACT) Inspector of Correctional Services, who investigates custody deaths, did this particularly effectively, drawing out in considerable detail how prisoners (see the example above) and also staff were supported after the incident. This should be replicated by other jurisdictions, and positive and poorer practice centrally collated and shared to grow understanding and prioritisation.

Conclusions

Although they faced considerable logistical, cultural and resourcing challenges, I identified a range of tangible examples of how prisoners can be better supported in the aftermath of a death. Differing personal preferences mean that the availability of a variety of available support sources – ranging from internal staff to external facilitators – is preferable to the simple provision of a one-size-fits-all, box-ticking support provision. Still, such initiatives need to be joined-up and championed by firm and empowering leadership.

Chapter four:

STAFF

Contents: *Debriefing – Organisational support – Employee Assistance Programmes – Peer support – External support – Return to work – Leadership – Longer-term support – Scrutiny – Vicarious trauma*

> *"We shouldn't have to think 'Who do I have to go and ask if I need to speak to someone?' We should be able to open an office door and do it off our own back."*[76]

This chapter reflects on potential support models for people working in prison after exposure to a suicide or suicidal behaviour.

Insights from my travel suggested that support for prison staff is more formalised than that for prisoners, with prison services as employers more likely to have processes established in policy and practice, for example through the quick deployment of serious incident teams to meet with those affected. Research literature on staff support is also more developed, reflecting an increasing understanding of the pressures faced by staff as a frontline cohort.

Yet prison staff face the double challenge of regular exposure to suicidal behaviour and serving in typically particularly neglected public sector roles. Canadian academic Rosemary Riccardelli has examined this issue in some depth. Her work highlights the importance of staff feeling validated in their actions and emotions, a particular challenge for those working in prisons who often start from a base level of feeling unappreciated, ignored and isolated.

Debriefing

I saw and heard about different models for debriefing in the immediate aftermath of an incident, with the best models being multi-stage, structured and reliable, and covering a wide catchment of people.

Debriefing should include specific time dedicated to emotional check-in and sharing of areas of support. Good practice is typically considered to involve an immediate session to note the experience and provide initial support, followed several days later by a fuller debrief to establish recovery steps after a brief period for processing has passed.[77] Debriefs should involve validation of, and education on, what feelings those involved may develop over time. Different services shared a range of examples of effective and digestible handout material that is also provided at such moments.

In Canada the Critical Incident Stress Management (CISM) approach

[76] Cultural Review of the Adult Custodial Corrections System, *Safer Prisons, Safer People, Safer Communities*, December 2022 [Link].

[77] Office of the Inspectorate, *Suspected Suicide and Self-harm Threat to Life Incidents in New Zealand Prisons 2016 - 2021*, September 2023 [Link].

included debriefing sometimes taking place off site, for example in a community space, to create greater opportunity for reflection. Such an approach was, however, often restricted by the familiar prison challenges of time and money.

Organisational support

I saw a range of centralised serious incident response processes put in place by prison services. These typically cover all major incidents, including assaults, use of force and escapes, as well as suicide response. Such teams frequently attend the relevant setting within 24 hours, with roles typically including playing a role in facilitating debriefing, checking in with those involved in the incident and providing psychological first aid and flagging support sources.

Such teams are often small and must cover an intimidatingly large geographic and thematic scope. Ricardelli's work has called for greater psychological support for staff, but I frequently heard from staff in response teams about ignored calls to central authorities for more funding for on-site psychological visits. This meant it was difficult to guarantee access on a particular day to everyone involved in a relevant incident, though in New Zealand the team told me that such individuals would be contacted via text or email if they were not physically present at the time.

New Zealand response teams also actively seek out those who had not been directly involved, including those who may have wished they had been on hand to help but had been unable to. They also provide guidance, including written products, which explain potential emotional, behavioural and physical reactions following a stressful incident.

Practitioners explained the importance of these response processes being formalised, and the frustrating and damaging implications of uneven support and blurred boundaries when this was not adequately done. Basic checklists for use by management can ensure steps taken are structured, predictable and take place in the right sequence.

In Victoria, Australia, prisons had access to a psychological wellbeing support service which could be used in a range of different ways, such as within group discussions and to support staff when reviewing difficult footage.

The availability of healthcare provision is also important. Staff in one prison I visited even commented on how healthcare support available to prisoners seemed greater than that provided to uniformed staff. Positively, one prison in Canada had provided staff with phone access to a mental health professional for two weeks after an inmate suicide.

Finally, in Canada one study included the suggestion from an interviewed officer that staff should be formally considered as 'first responders' to reduce the extent to which they are *"assessed or questioned when they require help for PTSD"*. It argues this

would require the provision of quicker access to care and improve staff morale.[78]

Employee Assistance Programmes

An Employee Assistance Programme (EAP), an employer-provided wellbeing advice service, is an important element of staff support structures. The intense, often chaotic nature of prison work, however, can mean predictable suggestions that traumatised officers should simply 'contact EAP' are often responded to with weary frustration.

Yet EAP programmes are not uniform, and I came across a range of innovative models which prompt useful ideas for contracts and delivery. EAP sources offer the clear benefits of being appropriately trained and offering a large degree of independence from

Innovations in EAP programmes

- Physical presence. I visited one prison in Australia which offers an in-person EAP service that was accessed frequently. They attend the prison several days a week and run both one-to-one and group sessions. In Canada the provider had the option of sending in-person counsellors, while another prison encouraged EAP services to make monthly visits, including from psychologists. While typically more expensive, in person services are simpler to access and also take some of the burden off the impacted individual being required to seek support proactively.
- Alternative communication methods. Reflecting a potential generational move away from phone conversation, Correctional Services Canada had plans to introduce online chat functions for staff as an alternative to conventional phone lines.
- Contracts which incentivise take-up. Some EAP services are rarely used or even known about, such are the challenges of reaching overworked frontline staff with messaging. Again, requiring staff to search on online intranets places much of the burden on those impacted to proactively seek assistance. In Canada the onus to make the service visible is placed on the provider themselves, by linking their pay to their usage.
- Peer EAP services. Staff often welcome support from trained EAP colleagues with lived experience compared to those with no real or perceived reference points to frontline operational realities.
- Feedback loops. Effective EAP providers provide useful, regular reporting and have dedicated meetings with prison leadership to facilitate better understand the implications of their interactions with staff.

[78] Ryan Coulling et al, '"We must be mentally strong": exploring barriers to mental health in correctional services', *Frontier Psychology*, January 2024 [Link].

prison leadership or line management chains.

Prison leadership has a responsibility to make these support sources visible and culturally acceptable to approach. Role modelling and promoting the benefits of take-up is also important: in an Australian prison, for example, I met the head of the incident response team who commendably openly commented in front of his wider team on the benefits he had gained from accessing EAP support.

Different jurisdictions still faced some familiar challenges with such services. For example, I heard familiar issues around the need to balance identifying the right EAP supplier and contract with the understandable preference to retain consistent contract terms for long enough to gather longer-term data on take-up and trends.

Peer support

Ricardelli highlights the importance of informal support networks in providing meaningful support to custodial staff, who often feel most comfortable talking to people with lived experience after an incident. It is vitally important that staff feel validated in their emotions after exposure to such incidents, and informal or formalised peer support can serve a directly relevant role in achieving this. Trust in the provider of any support source is vital to its success.

In Canada some staff are trained as EAP support who are educated on other resources available in the community. Some prisons I visited had staff designated as peer supporters who ran regular programmes of events raising awareness of how to access support and who had a cross-jail visibility, for example having door plaques drawing attention to their roles. It is important that feedback and escalation routes are available for such individuals, for example the option to feed up a chain to a regional representative who is able to lobby more widely on behalf of the staff their contacts have engaged with.

Such sources need not just be restricted to those in the same institution. The corrections department in one country I visited told me they had plans to develop a national network of peer supporters that all staff could contact after difficult incidents, broken down by role type, for use in instances when people wanted to speak to a peer though not someone they knew directly or who worked in the same prison.

It is important that peer support positions are properly selected, vetted and trained. Still, peer support need not come solely through formal or semi-formal routes: healthy organisational cultures, where staff support their colleagues and have a good understanding of suicide literacy, are often just as significantly beneficial in this context.

External support

There is some evidence that staff value and benefit most from effective internal support structures rather than external

bodies.[79] On the other hand, other experts highlight the danger of internal-only debriefing processes and of placing the burden of support on other people within an impacted team or group. Given the non-uniformity of individual preferences, the ability to access external support can be an important option for those exposed to suicide.

In an employment context where the perception of strength and resilience is vital, access to and validation by external sources can make a great difference to staff. External consultants with expertise leading responses to suicides can, for example, be effective facilitators of debriefing exercises.

In Canada, the Wounded Warriors organisation provides education and training on trauma management to front line workers, aiming to ensure they are *"safe, supported and understood"*.[80] The training focuses on managing the limbic system, the brain structures which manage emotions, after trauma exposure.

Delivery modes include a direct three-hour session for larger groups and a three day *"train-the-trainer"* course, a peer support model where recipients are subsequently tasked as teams of two to deliver what they have learned to the wider organisation within the next two years. The programme, created in consultation with those it delivers to, involves basic education, including usable language, and teaches skills in *"down-regulating"* following an incident.

Recognising the high vulnerability and risk faced by correctional officers, the programme has recently expanded to include prison staff, with pilots taking place in a range of federal prisons in Ontario. The organisation also arranges retreats with staff and their families. Initial feedback and outcomes have been positive, with the scalable approach appearing well-suited to effective roll out across a prison network. As with prisoners, this external support source, not directly affiliated with the prison service, has also appeared effective at breaking down cultural barriers to facilitate openness and reflection.

Return to work

The speed at which those involved in or impacted by a serious incident such as a suicide should return to work is contentious and nuanced. There is some evidence that staff are less likely to ever properly return to work if they take leave after an incident. Some practitioners I spoke to saw it as their central responsibility to get staff back to work as soon as possible, while others saw it as their duty to sensitively manage an iterative return.

A federal prison in Canada explained clear policy in this area involving return to work specialists and a range of options for returnees, including

[79] Karen Slade et al, *The impact of exposure to suicidal behaviour in institutional settings*, 2019 [Link].

[80] See Wounded Warriors [Link].

exposure therapy (a gradual return to the site, for example to the car park initially only) or reallocation to a different site. New Zealand takes a *"strengths-based"* approach to get staff back doing what is possible, for example integrating a staff member into an administrative or visitor reception role, as soon as practicable. Discretion and flexibility is surely the right approach for such circumstances, but this must be underpinned by a sensitive and supportive institutional culture, as well as consistency and predictability in what is offered.

Leadership

Leaders have a responsibility to openly recognise an incident and its impact on staff. When this is not done or delivered poorly it can have long-lasting ramifications. In one country I visited I heard how a visceral self-inflicted death had gone unacknowledged by senior leadership for several days, resulting in considerable anger among local staff which had even spread to those in other nearby prisons.

Leaders also have a role in celebrating and profiling colleagues when they have responded effectively, thereby promoting a supportive culture and disseminating good practice. In Canada I heard about an example in one prison where leadership had openly praised a staff member who had proactively supported a colleague in a mental health crisis.

Some officials reflected how senior leadership approaches to staff mental health was perhaps shifting with passing generations, suggesting it is possible that future leaders will place refreshing new prominence on facilitating support and celebrating good practice in this area going forward.

Longer-term support

Adrenaline-based responses can sustain first responders throughout the initial days and weeks after an incident. Centralised critical response teams are important, necessary and frequently impactful, though a number of people I met, for example inspectorates, flagged that after this immediate intervention, support can drop off completely. It is important that some form of support is maintained in the form of continued awareness and interventions relating to the prior suicidal exposure. This can be supported by suicide-literate staff able to identify the signs that somebody is struggling.[81]

Prisons should also track longer-term outcomes for those impacted by serious incidents. Staff should be asked about their support after a death, with data collected centrally and findings disseminated. Data on the reasons why people go on long-term sickness absence or resign completely should include exposure to traumatic incidents as a distinct category.

[81] This is also recommended by guidance in other criminal justice sectors. See International Association of Chiefs of Police, *Suicide Prevention, Intervention and Postvention: Policy Guidance for Law Enforcement Agencies* [Link].

Scrutiny

As with prisoner support, inspectorate and investigatory bodies have an important role to play in assessing and disseminating analysis of post-death processes and practice, for example through flagging where central critical incident teams have not been deployed following an incident or where feedback from staff on the level of support they received has not been positive. They can also play an important role in collecting and disseminating positive practice.

Vicarious trauma

Suicide research has frequently demonstrated the wide-ranging impact of a suicide, meaning it is important that those formulating aftercare structures think widely and proactively about the impact of vicarious trauma on those not directly involved in a death. This can include a wide range of staffing groups, ranging from frontline workers not directly involved in the incident, to regional suicide prevention teams, to even those with policy or oversight responsibility in national headquarters. As Australian organisation Lifeline explained, many people come into suicide prevention work because of their lived experience – this is mostly a significant benefit to their roles, though can also represent a characteristic which can increase their risk.[82] Leaders should acknowledge and be aware of the impact of vicarious trauma for those in such positions and put in place the relevant support structures and cultures to help them.

Conclusions

Some interviewees were keen to note their acknowledgement that prison staff are not the only public sector workforce where support in the aftermath of traumatic incidents can be lacking. Indeed, some even felt correctional staff had greater structures in place than those in the community. However, the perceived and actual neglected nature of prison settings can heighten feelings of isolation and neglect. The intense geographies and repressed communication cultures of prisons also mean creative, proactive and reliable support structures are highly necessary for staff across all roles and grades.

[82] Panel discussion on psychological hazards at the 2024 National Suicide Prevention Conference, Adelaide.

Chapter five:

INVESTIGATIONS

Contents: *Investigation approaches and processes – Inquests approaches and processes – Preparation and education – Improving feedback loops – Process reviews*

> *"You try to do your best at the time and you try and save people's lives but you're always asked what more you could have done."*[83]

This chapter also focuses on staff, but specifically examines the later stages of the post-death process: the investigation and inquest (or their equivalents), which most often take place months and even years after the initial incident.

Investigation and inquest processes differed slightly across the different countries in scope of this research. I consistently saw, however, how these experiences can be retraumatising, especially when the wait, as was the case everywhere I travelled, for them to take place is long. This is an increasingly researched area, and interviewees on my trip were quick to highlight it as one of considerable concern.

Overall, there appears to be much more that could be done, with staff in many jurisdictions calling out for greater assistance than just formulaic signposting to EAP services. Ultimately, revisiting incidents and repeating narratives can, when done properly, have a healing effect, rather than a retraumatising one.

Investigation approaches and processes

It is right that deaths in custody, and especially suicides, are thoroughly investigated, with issues identified and corrective actions put in place to mitigate the factors that caused them. These processes must be robust in order to accurately establish what took place. There is a difficult balance, though, to strike between delivering a rigorous assessment of an incident which provides reassurance on the safety of a core public service with one that avoids further damaging those who are required to relive it.

This concern is recognised in international guidelines, with the Minnesota Protocol on the Investigation of Potentially Unlawful Death outlining an expectation that:

> *"investigators must take care to minimise the harm that the investigation process may cause, especially regarding the physical and mental well-being of those involved in the investigation."*[84]

[83] HM Inspectorate of Prisons for Scotland, *Independent Review of the Response to Deaths in Prison Custody*, November 2021 [Link].

[84] Office of the United Nations High Commissioner for Human Rights, *Minnesota Protocol on the Investigation of Potentially Unlawful Death*, 2016 [Link].

Negative outcomes in this area are partly down to investigator methodology. One interviewee described the *"hindsight bias"* prevalent in prison death investigations, where those involved seek to identify a missing piece in a process in an attempt to find a straightforward fix, rather than looking at a system that has contributed to the death as a whole. Equally, the process and its final product can often fail to illuminate positive practice, or note that someone particularly vulnerable was possibly kept alive for longer within the prison structure as a result of effective care.

Compliance-driven lines of inquiry – as in, those that test the degree to which someone has adhered to central policies, some of which can be detailed and obscure – are also not only of limited long-term value, but can be particularly oppressive for staff.[85] One medical expert outlined how his organisation routinely has clinicians *"beaten up"* by investigations, with family lawyers *"leaping"* on any mistake that has been made. Investigation models that seek to identify bigger-picture policy gaps and underlying issues are likely to prompt greater engagement from responsible authorities and have more productive future-proofing value.[86]

Similarly, I heard frustrations where recommendations looked to *"plug a hole"* as a result of a specific case, often subsequently resulting in little more than additions to already complex and overloaded policy documents, which frontline staff had little exposure to or time to examine in any case. This is amplified in cases where policies are already too long or contradictory, another frequently raised concern.[87]

Investigators themselves should always seek to apply an introspective and self-critical view on the impact their work is having on people who may have been deeply impacted in complex ways by the incident and may already be at a heightened risk of reaggravation. The Office of the Inspectorate in New Zealand, which includes deaths investigations in its remit, told me that it adopts trauma-informed lines of interview for this purpose.

Investigation processes should be clear, transparent and fair. When they were not – for example, where the selection process for members of an investigation was unclear and unpredictable – it resulted in confusion and resentment of an already unpleasant process. More positively, the New Zealand inspectorate outlined how they spend time with staff explaining their line of questioning to support them through the process. Clear, accessible and proactively

[85] See Royal College of Psychiatrists, *Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework*, December 2022.

[86] This is a complex issue in itself, though from the perspective of staff support, such an approach appears most beneficial.

[87] This also, of course, raises a separate issue about the validity, usefulness and accessibility of centrally mandated policy documents.

shared information should be available, including in relation to the remit of an investigatory process.

Investigations should also be as quick as possible. In some jurisdictions, I heard how reviews can take up to a year to complete, creating significant anxiety for staff over time. In addition, the longer they take, the less likely the resulting findings are to be teachable and relevant.[88]

Investigations models

- New Zealand. Investigations are carried out by a team of two inspectors employed by the Office of the Inspectorate, which organisationally forms part of the Department of Corrections. Reports are detailed and appear extensive, though are not made publicly available.
- Australia. Varies by state. The Australian Capital Territory Custodial Inspector carries out independent investigations, which commented on aftercare provisions and are publicly available. Investigations into deaths in New South Wales are internal only. A Management of Deaths in Custody Committee oversees reporting and the implementation of recommendations.
- Canada. Deaths in federal prisons are investigated by a Board of Investigation, typically made up of experienced national investigators, service employees as well as an independent community member. Reports are finalised four times a year, though are not published. Investigations are set up by Correctional Service Canada (as in, they are not conducted 'independently').

Inquest approaches and processes

Inquest models varied across the jurisdictions I visited. This included differences within individual countries: for example, there was considerable variation in set-ups in Canada, ranging from particularly thorough yet time consuming coroner-led models, to medical examiner approaches, which are typically quicker.

Inquests, often characterised by courtrooms full of suited lawyers and persistent lines of interrogative questioning, can be deeply intimidating and retraumatising for staff, many of whom will not have been directly at 'fault' for a death. Prison officers report feelings of fear, anxiety and isolation ahead of an inquest, which are particularly prevalent when encountering a bereaved family.[89] I saw this at an inquest in Australia, when a witness was subjected to

[88] This is another issue that is not a straightforward issue to remedy.

[89] Alison Liebling, *Suicides in Prisons*, 1992.

lengthy questioning and requests to justify her actions alongside video footage, despite it being acknowledged that her actions had no impact on the death. Efforts should be taken to ensure that witness exposure to and involvement in the process is kept to a minimal level.

Some spoke about coronial processes also verging too far towards the *"missing piece"* approach in their analysis of a case. Encouragingly, interviewees commented on how in Victoria, Australia they were seeing a shift away from a perceived fixation over policy compliance, partly through the development of Coroners Prevention Unit. Such challenges are amplified by delays, meaning inquest findings can often end up out of date before the process is even completed.

Alternatives to inquests

Most jurisdictions I visited used a similar process to the inquest in England and Wales, though a range of interviewees also highlighted alternative frameworks that can be applied to this phase of the post-death process.

- 'Just culture' models. Seeks to avoid blame, and consider negative outcomes within the contextual framework of an organisation rather than as a result of individual actions.
- Medical examiner scrutiny. Rather than involving a coroner (i.e. a judicial office holder), death reviews can also be overseen by medical professionals with relevant expertise. This tends to be a quicker, though narrower, approach.
- Psychological autopsy. Avoids focus on blame, and instead seeks to build an assessment of an individual's state of mind ahead of their death to identify what can be done in future similar incidents.

Preparation and education

Prison services, investigators and coroners all need to take seriously their role in establishing and managing expectations and educating people on what to expect through these processes. Transparent appropriate information sharing should be prioritised to ensure participants have the best possible understanding of what is likely to take place throughout the proceedings.[90]

Perceptions among prison staff of inquest, for example, can vary wildly: some have a sensationalised impression of how distressing the experience will be, while others are taken aback by its adversarial nature – as coroners were quick to remind me, after all these are court proceedings,

[90] Rosemary Ricciardelli et al, 'Testifying after an Investigation: Shaping the Mental Health of Public Safety Personnel', *International Journal of Environmental Research and Public Health,* 19.20, 2022 [Link].

and cases which result in an inquest are often highly contentious and complex. Others have no concept at all of what to expect.

Prisons must also take seriously their responsibility to prepare staff for investigations, clearly explaining realities and providing relevant trauma support. Prison leadership exhibited some positive practice in this area. Encouragingly, for example, some prisons in Canada provided training on what to expect from investigations, while in New South Wales, Australia, the Corrections department planned to reintroduce training on what is likely to happen during an inquest for staff.

Dedicated support outlets should be available as support during these processes. In Canada the central corrections department had introduced a phone line to a dedicated counsellor for those going through a particular inquest. This had been well received, and there were plans in place to apply the model to future incidents.

Investigators also have a role to play in preparing those involved. In New Zealand, the Inspectorate informs clinical managers about the staff they want to interview in advance so they can be prepared.

For their part, coroners and their supporting offices consistently raised the issue of underfunding, and pointed to how this undermines their ability to provide education and support to those involved. One Chief Coroner told me about an ambition to create a more people-centred court that had been stymied by funding challenges. Again, I found pockets of good practice, for example in Australia some coroner courts employed a *"navigator"* role to support those involved.

Improving feedback loops

The purpose of investigatory processes is to learn from tragic events to prevent them from reoccurring. Yet feedback loops after an investigation or an inquest are frequently poor, ultimately meaning that opportunities for those at the frontline to adapt their practice is lost. This compounds the challenges faced by staff participants: unaware of any resulting positive outcomes, staff repeatedly conclude their experiences with minimal evidence of anything beneficial having come from them, leading in turn to further heightened suspicion and anxiety.

Investigators I spoke to were often not confident that their findings were being shared widely. I met staff who said they may only hear about the outcome of a report second hand if their conduct was negatively referenced. Staff regularly admitted that they often did not know about recommendations or actions taken in response to investigators, nor where to find this information.[91] I was surprised to find

[91] Robert Cormier, Gareth Jones and Louise Leonardi, *Fifth Independent Review Committee on Non-natural deaths in custody that occurred between April 1st, 2017 to March 31st, 2019,* 2023 [Link].

that investigation outcomes were not published in the majority of the jurisdictions I visited.

Senior leaders were often, I heard, the sole recipients of reports. This means they have a responsibility to disseminate findings, including positive areas of practice. As a typical example, leaders in Canada are debriefed by investigation boards and then disseminate findings via emails, shift briefings and manager meetings. Such processes should be reliable and have proper time dedicated to their delivery. Ideally, findings from investigations should be transparently discussed to ensure some benefit comes from such draining processes. Leaders also have a responsibility to acknowledge the challenging processes that their staff have gone through. Prison managers should map out all opportunities their staff have for receiving information, feedback and challenging messages, and take steps to adapt their dissemination of investigation outcomes accordingly.

Investigators also have a responsibility to adapt their outputs to ensure they have maximum impact and are sufficiently digestible to be assimilated into policy and practice. This should include consideration of how findings from individual cases can be summarised thematically, and how outputs can be tailored and distributed to proactively ensure they reach the frontline. It is not enough to complete an investigation and then simply move on to the next one. Some investigators admitted that thematic learning analysis is among the first function to be paused in the event of capacity or funding pressures.

Process reviews

It is important that post-death processes are kept consistently under review to examine their impact and mitigate their potential harms. This requires a willingness to be open to external scrutiny and courage to respond to criticisms on an emotive issue. I saw a particularly advanced approach to this in Canada, where since 2007 the independent review committee on non-natural deaths in custody process has played a useful role in highlighting instances where post-death processes have not been followed or their impact undermined. This model involves the infrequent formulation of small expert panels with specific terms of reference who conduct an extensive review resulting in a published report and accompanying recommendations.

These reviews are a good example of how regular, transparent and considered reviews of investigation processes can focus minds on ensuring the purpose of investigations are being met, and negative fallout managed. They clearly require a not insignificant amount of work and resource to set-up, service and respond to. But this system-wide, expert-led assessment model can at least help reassure those involved in these processes their effectiveness is under regular independent review.

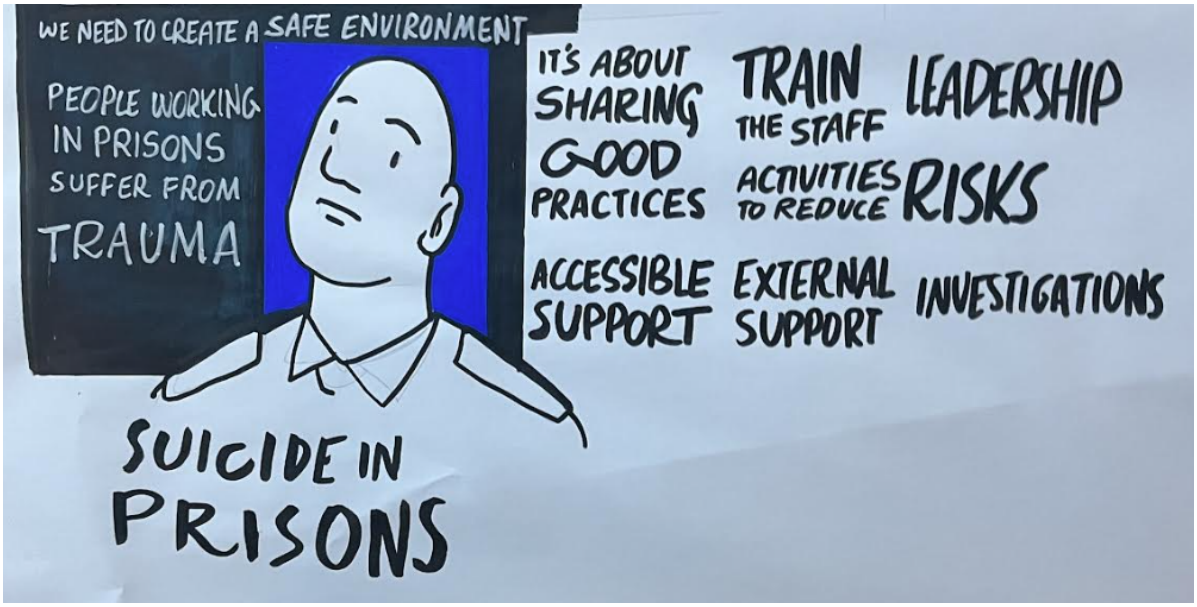
Conclusions

Even if staff are adequately supported in the immediate aftermath of a death, the draining experiences of subsequent investigations and inquests mean the recovery process can be damagingly prolonged. This is not to take away from the need for thorough reviews, nor to suggest that individuals who have made serious errors should not face scrutiny and consequence. But all parties owe it to those who have experienced a traumatic event to prepare them for it safely and thoroughly and adapt their methodologies to ensure potential for further harm is limited. Just as importantly, outcomes and tangible learning from such exercises should be transparently and accessibly consolidated, shared and meaningfully reflected on.

Chapter six:

CONCLUSIONS

Contents: *Concluding reflections – Key suggestions for policy and practice – Next steps*



Live visual minute by More Than Minutes from the Royal College of GPs Secure Environments Group conference, October 2024, London, where I presented my findings. Photo by the author.

Concluding reflections

The impact of a suicide in prison is devastating for the bereaved family. Yet without compassionate, varied and structured support, it can also be severely damaging for other prisoners, as well as those charged with their oversight and care as staff.

My Churchill Fellowship project has aimed to achieve a better understanding of the viability of postvention provision in prison, and to examine potential models for good practice. It has aimed to scope out the challenges faced in establishing good practice postvention procedures and cultures within the unique context of a living prison. It has examined how prisoners, who have frequently experienced a range of prior traumas, can benefit from more structured support alongside an appropriate dose of *"sincere connection"*. Staff, who already frequently feel neglected and underappreciated, can be aided after suicide exposure by considered internal structures, but also the option to access external support which takes the burden off the team affected by the incident to provide it. My report has also set out the need for prison leaders, investigators and coroners to examine and adapt their approaches to mitigate the damage of subsequent lines of investigation and scrutiny.

My research demonstrates how everyone involved in such a harrowing and complex event should have the option to draw from multiple support sources, as well as the requisite space

and time to enable them to process it. Just as prison suicides are complex and driven by factors ranging from broad and complex systemic issues to hyper-local or individual-specific causes, so are the factors that produce differing reactions in their aftermath highly intricate and unpredictable. But strategic prioritisation, comprehensive mapping of potential contact points and support sources, and informed education for everyone who may interact with someone impacted can help mitigate and control this risk.

Understanding and embedding of postvention and aftercare in prisons is clearly in its early stages. I only found patches of good practice, such as the advanced role of well-embedded prison chaplains in New Zealand, or the trialling of external support processes for either prisoners (such as StandBy in Australia) and staff (such as Wounded Warriors in Canada). Yet the existence of good practice, despite the considerable challenges posed by the prison environment, and signs of increasing enthusiasm from central authorities to consider the issue strategically, suggests the development of mature prison postvention measures is possible. As is often the case with all efforts to establish healthy prisons, its development, delivery and championing must start with firm and compassionate leadership. It is important that postvention evolves into a key element of an ongoing push towards active prison suicide prevention.

As with wider suicide prevention, prison postvention should be aligned to broader prevention strategies in the community. Oversight of, and duty for, its delivery and embedding should form part of national-level priorities, rather than resting solely with justice or justice health bodies.

My key conclusions are set out below.

Key suggestions for policy and practice

1. Postvention is important, and prisoners and prison staff are particularly in need. It should be an **organisational priority** to ensure appropriate responses are embedded within local and national strategies.

2. All **prison leadership tiers** have a crucial role to play in establishing safe psychological environments with reliable information exchange and high levels of **suicide literacy** across both the staff and prisoner populations. Leaders should ask their prisoners and staff how they can best support them and what sources of support they want.

3. Available support sources should balance the procedural and pastoral, and need to be **joined-up and multi-agency**. Different people need different responses at different times. All groups involved in the aftermath of a death should be aware of their likely touchpoints with those impacted

and the potential roles they can play. These should be mapped out and work taken forward to ensure everyone understands their potential role.

4. People need access to support from both **long-term** internal relationships they can trust and **external support** sources outside of familiar structures. Both need to be made available and refined according to needs and feedback.

5. Services must do more to understand and address the retraumatising impact of **investigations and inquests.** This can come through improved education on relevant processes as well as from signposting and developing relevant support sources. This duty should also fall on investigators, coroners, and other relevant staff.

6. Greater understanding of delivery is required. **Investigation and scrutiny** bodies have a responsibility to identify and analyse post-death processes so good practice can be shared and understood. These should be publicly available, and prisons should have structures in place to meaningfully reflect on and take forward their findings.

Next steps

I look forward to working with relevant individuals and organisations to share and discuss my findings and recommendations postvention responses to ensure prisoners and staff receive the support they need in the aftermath of a suicide. I will seek to identify the types of policies and ways of working in which my findings can be embedded and maintain networks abroad to understand international developments. Ultimately, I hope to see postvention better understood and integrated into increasingly mature, but still desperately needed, suicide prevention efforts in custody.

Appendix one:

KEY READING

The below list sets out key reading that I have drawn from frequently in this report.

New Zealand

- Peter Boshier (Chief Ombudsman), *Making a Difference: Investigation into Department of Corrections*, June 2023 [Link].
- Department of Corrections, *Suicide Prevention and Postvention Action Plan 2022-25*, October 2022 [Link].
- Office of the Inspectorate, *Suspected Suicide and Self-harm Threat to Life Incidents in New Zealand Prisons 2016 - 2021*, September 2023 [Link].

Australia

- Cultural Review of the Adult Custodial Corrections System, *Safer Prisons, Safer People, Safer Communities*, December 2022 [Link].

Canada

- Robert Cormier, Gareth Jones and Louise Leonardi, *Fifth Independent Review Committee on Non-natural deaths in custody that occurred between April 1st, 2017 to March 31st, 2019,* 2023 [Link].
- Ontario Chief Coroner's Expert Panel on Deaths in Provincial Custody, *An Obligation to Prevent: Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody*, January 2023 [Link].

Other

- Colette Barry, '"You just get on with the job": Prison officers' experiences of deaths in custody in the Irish Prison Service', *Prison Service Journal*, 2017 [Link]
- HM Inspector of Prisons, *Improving behaviour in prisons: A thematic review by HM Chief Inspector of Prisons*, April 2024 [Link].
- HM Inspectorate of Prisons for Scotland, *Independent Review of the Response to Deaths in Prison Custody*, November 2021 [Link].
- Royal College of Psychiatrists, *Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework*, December 2022.
- Samaritans, *Pilot of Postvention Support in Prisons*, July 2020 [Link].
- Karen Slade et al, *The impact of exposure to suicidal behaviour in institutional settings*, 2019 [Link].