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Reconceptualizing multisectoral prison regulation: Voluntary organizations and bereaved families as regulators

Philippa Tomczak
University of Nottingham, UK

Abstract

Prison health, prisoner safety and imprisonment rates matter: intrinsically and for health and safety outside. Existing prison regulation apparatuses (e.g. OPCAT) are extensive and hold unrealized potential to shape imprisonment. However, criminologists have not yet engaged much with this potential. In this article, I reconceptualize prison regulation by exploring the work of a broad range of multisectoral regulators who operate across stakeholder groups. I illustrate that voluntary organizations and families bereaved by prison suicide act as regulators, although their substantive actions have been erased from official narratives. Mobilizing (threats of) litigation, these actors have responsibilized the state and brought qualitative changes across the prison estate.

Keywords

non-governmental organizations, OPCAT, poststructuralism, prison oversight, prison suicide, voluntary sector

Introduction

Prison health, prisoner safety and imprisonment rates matter: intrinsically, to anyone interested in their fellow citizens' rights and well-being, and for health and safety throughout societies. Prison regulation is an important 'counterweight to potential abuse of the special powers of the state' (Hood et al., 1999: 116), made only more urgent by neoliberal carceral expansionism in many jurisdictions (Bosworth, 2011; Wacquant,

Corresponding author:
Philippa Tomczak, Principal Research Fellow, School of Sociology and Social Policy, University of Nottingham, Nottingham, Nottinghamshire, NG7 2RD, UK.
Email: Philippa.tomczak@nottingham.ac.uk

2010), the globally expanding prison population (Penal Reform International, 2019) and the COVID-19 pandemic. Regulation, broadly defined here as 'steering the flow of events and behaviour' (Braithwaite et al., 2007a: 3), is concerned with improving performance and holding key personnel responsible for it. Regulation encompasses sanctioning and supporting activities, most frequently involving education and persuasion but potentially escalating to litigation and prizes (Braithwaite et al., 2007b). Regulation has transformed some public services (Smith, 2009) and can influence conditions and treatment in institutions (Braithwaite et al., 2007b). As John Braithwaite and his colleagues (2007a: 4) put it: 'good regulation can control problems that might otherwise lead to bankruptcy and war, and can emancipate the lives of ordinary people . . . Regulation matters, and therefore the development and empirical testing of theories about regulation also matter.' Existing prison regulation apparatuses are extensive and hold substantive, yet unrealized potential to (re)shape imprisonment; for example, by seeking to improve prison health and safety for the benefit of prisoners, staff, families and the societies from which prisoners come and almost always return. Nevertheless, a great deal more research is required to inform and understand the (potential) impacts of regulation on prisons and societies (Padfield, 2018; Rogan, 2019).

In the most comprehensive account to date, Van Zyl Smit (2010) maps multiscalar prison regulation. Yet, reflecting regulation scholarship more generally, his *state-centric* account stops short of exploring a wider regulatory landscape, where private actors play very significant regulatory roles (Grabosky, 2013). Substantive literatures detail how prisons should and could operate: for example, (inter)national case law and guidance including the UN Mandela and Bangkok Rules and European Prison Rules (Rogan, 2019; Van Zyl Smit, 2010); and scholarship examining prison moral and social climates (e.g. Liebling, 2004). It is however unclear how laws, overseers' recommendations, guidance and knowledge can more consistently influence prison safety in practice (Tomczak, 2018). Moreover, significant resources are invested in prison oversight, undertaken by paid staff and thousands of volunteers (Tomczak and Buck, 2019a), with little understanding of whether these resources are being usefully expended.

Using data generated during three years of qualitative research (2015–2018) on relationships between prison suicide and regulation in England and Wales, I illuminate how voluntary organizations and families bereaved by prison suicide act as regulators. (Threats of) litigation following multiple self-inflicted deaths at (1) Her Majesty's Prison (HMP) Styal, (2) Her Majesty's Young Offender Institution (HMYOI) Aylesbury and (3) HMP Woodhill have brought unrecognised changes across the prison estate.

I argue that developing a rigorous and nuanced theory of multisectoral prison regulation, could form a productive means for scholars and community partners to *do more* than documenting the harms of mass incarceration, and thereby map a more optimistic way ahead (Bosworth, 2011; Carlen, 2001; Zedner, 2002). My reconceptualization offers new and more numerous ways to question assumptions and hierarchies in existing prison regulation scholarship and think about how prison regulation and (mass) imprisonment could be otherwise. It also suggests how many jurisdictions' bloated prisons, which frequently confine disproportionately minority populations and pose risks to societal safety, could be subject to greater, sustained challenge.

Unsafe prisons mean unsafe societies

Addressing prison safety and prisoner health is now more urgent than ever before. Prisoner mortality rates are up to 50% above those in the community (UNOHCHR, 2019: 9). Almost 11 million people are imprisoned globally, of whom 30% have not been convicted (Penal Reform International, 2019). These people are unable to leave environments that concentrate 'poverty, conflict, discrimination and disinterest' (WHO, 2000: 11).

Current austerity conditions in many English prisons imperil the health and well-being of prisoners and staff (Ismail, 2020). Unsafe prisons also reduce safety outside. Higher reoffending rates correlate with (1) poorer prisoner health (Link et al., 2019) and (2) poorer prison social climates (Auty and Liebling, 2020). Reoffending in England and Wales costs £18.1 billion annually, while creating new harms (e.g. trauma) daily (Newton et al., 2019).

The issues are not confined to penal institutions. Prison health is public health (McLeod et al., 2020). Rates of disease, drug dependency and mental illness in prison populations far exceed those outside (UNOHCHR, 2019: 9). Globally, ~30 million people are released from custody annually, so prisons are a vector for (community) transmission of infectious diseases, disproportionately impacting marginalized communities (Kinner et al., 2020). Mass imprisonment is itself a social problem, producing invisible, cumulative, intergenerational social inequality (Simon, 2012; Western and Pettit, 2010).

Prison regulation

Criminologists have extensively examined how criminal justice institutions regulate, steer and control (e.g. Simon, 2007). Scholars have highlighted the disproportionate criminalization of (multiply) marginalized groups including: the poor (Wacquant, 2010); people of colour (Miller and Stuart, 2017); women (Carlen and Tombs, 2006); women of colour (Russell and Carlton, 2013). Steering and checking *of criminal justice institutions* themselves has, however, received relatively little scholarly attention (Seddon, 2010).

Braithwaite (2003: 11) gestured at 'a paradoxical feature' of the new privatized, regulatory state, which sees the state, including its criminal justice system, becoming 'an object as well as a subject of regulation'. Nevertheless, criminologists have focused on the limited capacities of piecemeal regulatory mechanisms to stimulate penal change; for example regarding: (1) prison law and inspection (Maguire et al., 1985); (2) inquests (Razack, 2015; Scraton and Chadwick, 1986); (3) official inquiries (Gilligan and Pratt, 2013); (4) complaints (Calavita and Jenness, 2013). Critical accounts are crucial, but scholars must not overlook the potential of regulation to reshape imprisonment, which should include efforts to improve conditions and shrink imprisonment rates (Mathiesen, 1974). Prison regulation cannot be the sole preserve of reformists, as those prioritizing anti-carceral agendas must not forget those real people, who often need immediate resources, that are already caught up in detention (Carlton, 2018).

Regulating all forms of state detention is a global imperative, as highlighted by the 2006 Optional Protocol to the United Nations Convention against Torture and Inhuman or Degrading Treatment or Punishment (OPCAT).[1] The growing number of ratifying jurisdictions[2] must establish National Preventative Mechanisms (NPMs) to undertake

regular detention visits (e.g. Cliquennois and Snacken, 2018; Murray et al., 2011). NPMs form extensive apparatuses with potential to shape detention, but many 'have been established at great speed', without evidence demonstrating 'how NPMs have gone about their task and "what works"' (Hardwick and Murray, 2019: 85).

Ontological approach

In criminological scholarship, dystopias often prevail. For example, teleological depictions of ever-proliferating governmentality can obfuscate any possibility to pursue the crucial criminological projects of remoralizing carceral regimes and deconstructing the carceral state (Bosworth, 2011; Carlen, 2001; Zedner, 2002). Adopting poststructuralist processual social ontology can, valuably, avoid determinist dystopias. Processual social ontology presumes that everything in the social world is continually being made, remade and unmade (Abbott, 2016; Herbert-Cheshire, 2003; Renault, 2016). The processual focus on emergence contrasts with, for example, Foucauldian notions of apparatus, regime or governmental technology, or Durkheim's focus on grand social entities.

Conventional 'topographical' depictions of power enable the contours of authority to be mapped across defined areas, resting on conceptualizations of fixed relationships and well-defined proximities between actors, which have been likened to a flat, well-ironed handkerchief (Serres and Latour, 1995). Such 'topographical' depictions of power cannot capture the complex reworkings of authority that now shape the world (Allen, 2011). By contrast, power 'topologies' see actors making their presence felt, in more or less powerful ways, that can cut across proximity and distance. Being represented by a crumpled handkerchief, 'topological' power can create distance between once close weaves and place previously separated points in contact (Serres and Latour, 1995). As such, in a multiscalar, 'topological' configuration of (prison) regulation, *power is able to 'jump' across scales rather than operating through state-centric hierarchies*. Seen through this lens, some public and private sector regulators can, or could, transcend conventional landscapes of fixed distances and defined priorities in order to exert an influence and reach way beyond their means and resources (Allen, 2011).

Drawing on insights from processual social ontology (Abbott, 2016; Renault, 2016), I reconceptualize prison regulation as a precarious product of heterogeneous actors and explore a broader range of multisectoral regulators, operating across stakeholder groups and involving unconventional operations of power. In my conceptualization and subsequent analysis, multisectoral regulators (hold the potential to) do more than deflect attention from the systemic, cultural, operational and policy issues that bear upon prisoner well-being and distress, as critical accounts generally conclude (Razack, 2015; Scraton and Chadwick, 1986; Sim, 2019).

My reconceptualization is underpinned by three analytical clean slates (Law, 1992): (1) that ever-expanding imprisonment rates, poor prisoner treatment and conditions are not inevitable (Bosworth, 2011); (2) that prison regulation must not always be ineffective and 'toothless' (Hood et al., 1999); (3) that extending the spectrum of groups that (could) shape imprisonment and responsibilize the state is a productive project which could challenge poor prison safety, poor prisoner heath and high imprisonment rates.

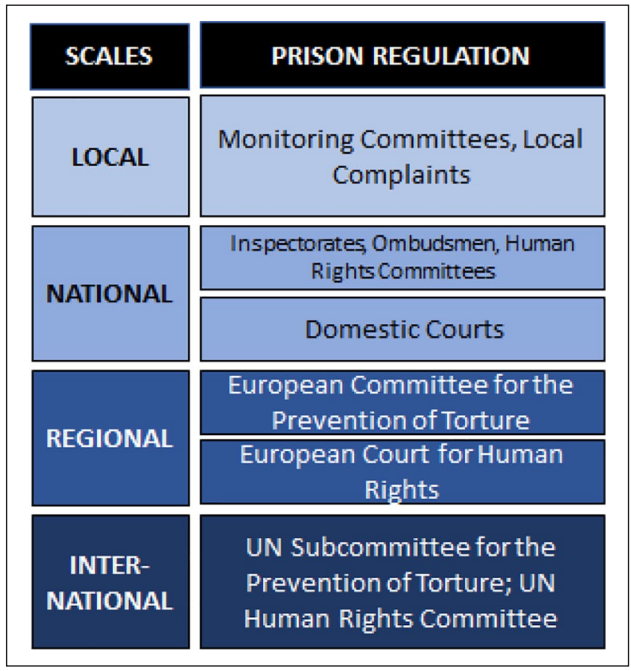

Figure 1. Multiscalar, state-centric prison regulatory formations (following Van Zyl Smit, 2010).

Multiscalar prison regulation

In the most comprehensive account to date, Van Zyl Smit (2010) maps multiscalar prison regulation,[3] detailing local, national, regional and international regulators but privileging (quasi-)statutory regulators. Local formations include individual prison monitoring committees and complaints procedures. National formations include inspectorates, human rights committees, ombuds institutions and domestic courts. Regional formations include the European Committee for the Prevention of Torture (applies the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment); and the European Court of Human Rights (applies the European Convention on Human Rights). International formations include the UN Subcommittee for the Prevention of Torture (applies OPCAT) and the UN Human Rights Committee (applies the International Covenant on Civil and Political Rights). Figure 1 presents multiscalar, state-centric prison regulation.

Although 21st-century governance is a crowded affair, interdisciplinary scholarship still provides limited knowledge 'about relevant . . . actors beyond "the usual suspects"' in state bureaucracies (Stark, 2019: 7). For example, Van Zyl Smit (2010: 506) highlights (inter)national courts' role in external monitoring of prisons (see also, for example, Feeley and Rubin, 2000; Schoenfeld, 2010; Simon, 2019 regarding the USA). However, to examine courts without considering *how and through whom cases come before them*

is to reproduce the myth of rights: that all victims are assured of their day in court and judicially affirmed rights are self-implementing social justice instruments (Scheingold, 1974). Courts do not act on their own: actors must bring cases (Cliquennois and Champetier, 2016) and doctrinal law operates through people, social relationships and material environments (Davies, 2017). Similarly, public inquiries and independent reviews do not simply emerge, but often result from sustained pressure by non-governmental groups; for example, by bereaved families and communities (Cliquennois and Champetier, 2013; Cooper and Lapsley, 2019; Scraton, 2016).

Accounts of prison regulation too frequently position voluntary/non-governmental organizations (NGOs) as supplementary,[4] acting by pressuring statutory regulators. For example, (inter)national NGOs (e.g. Amnesty International and national Howard Leagues) apparently 'operate as a pressure group [. . .] to encourage government or other bodies to perform their regulatory functions' (Van Zyl Smit, 2010: 506; see also Whitty, 2011: 133–140). Moreover, voluntary organizations' responsibilization by the state has often been emphasized. Responsibilization refers to non-state actors being rendered responsible for tasks previously the duty of state agencies and is strongly associated with neoliberal political discourses (O'Malley, 2009). Economic retrenchment has driven some voluntary organizations to become key players in mixed penal services markets (Ransley and Mazerolle, 2017), and weakened contestation, deliberation and redistributive work (Tomczak and Buck, 2019b). The UK government's message is clear: 'the role of voluntary organisations is to efficiently and cost-effectively deliver services. Those who campaign run the risk of being blamed for wasting taxpayers' money and playing politics' (Ishkanian and Ali, 2018: 7). Some evidence exists of voluntary organizations refusing to perform their prescribed uncritical service-delivery roles, regulating imprisonment and responsibilizing the state. However, such cases have not been integrated into the prison regulation or responsibilization literatures. For example, following swingeing legal aid cuts under the Legal Aid, Sentencing and Punishment of Offenders Act 2012, through a 2017 Court of Appeal decision,[5] two English voluntary organizations (the Howard League and the Prisoners' Advice Service) restored legal aid for prisoners seeking pre-tariff Parole Board reviews, Category A classification reviews and Close Supervision Centre placements (see also Valier, 2004).[6] These efforts represented direct, coercive regulation through escalating sanctions (Grabosky, 2013), rather than action subsidiary to statutory regulation (Van Zyl Smit, 2010; Whitty, 2011).

Similarly, prisoners' (bereaved) families can and do regulate imprisonment, but this role is rarely acknowledged in either the prison regulation or prisoners' families scholarship (e.g. Condry and Minson, 2020). For example, the Joint Enterprise Not Guilty by Association (JENGbA) grassroots organization comprising many prisoners' family members played a significant role in modifying joint enterprise legislation.[7] In collaboration with academics and lawyers, JENGbA have highlighted the discriminatory use of joint enterprise law, supported appeals and lobbied for legal changes (Williams and Clarke, 2016). Scraton (2016) documented the collective contribution of Hillsborough bereaved families and survivors over three decades in establishing 'the truth'. Stephen Lawrence's family have campaigned since his 1993 murder and profoundly influenced policing (e.g. Hough et al., 2018). Actors from diverse sectors are germane to regulation (Grabosky, 2013) and by suspending state-centric assumptions, we can make a broader

spectrum of (potential) regulation visible (Dunlop and Radaelli, 2017). I now demonstrate how voluntary organizations and bereaved families have regulated imprisonment following multiple prison suicides.[8] My analysis focused on post-death regulatory responses, but prisoners have themselves acted in this process and also regulate imprisonment in radical (Cummins, 1994) and everyday ways (Bosworth, 1999).

Methodology

Prison suicide forms a valuable point of analytical departure, reminding us that 'it might have been otherwise' (Star, 1990: 53). Suicide is the single most common cause of death in corrections (WHO, 2007: 1) and threatens 'the most fundamental of all human rights, the basic pre-condition of the enjoyment of other rights': the right to life (Owen and Macdonald, 2015: 121). Detention deaths represent the extreme end of a continuum of near deaths and injuries which can illuminate health and safety harms, risks and abuses more generally (Coles and Shaw, 2012: 2).

The research objectives were to consider how prison suicide is regulated, who is regulated and who regulates it. Data were gathered through (1) very extensive document analysis and (2) semi-structured interviews with multisectoral stakeholders. Document analysis included over 100 Prison and Probation Ombudsman fatal incident investigations and Coroners' Reports to Prevent Future Deaths.[9] Only deaths classified as 'self-inflicted' were included. The sample was gathered in reverse chronological order and contained deaths from 2012–2017. These Ombudsman and Coroner reports about individual deaths were triangulated through substantive reference to further 'official' documents, including annual and individual prison reports from the Inspectorate, annual reports from prison Independent Monitoring Boards and reports on visits by international committees (Tomczak, 2018). These detailed, publicly available documents are an underutilized data source, providing extensive information about deaths, prisons and responses to prison deaths over time. Published documents thus offer significant potential for further (longitudinal) scholarship. Sixteen stakeholders were interviewed on a confidential, individual basis. Ten were (quasi-)statutory prison regulators, five were voluntary sector regulators and one was a bereaved partner. Invited stakeholders included: Coroners; all local and national (quasi-)statutory regulators (e.g. representatives of prison Independent Monitoring Boards, the Inspectorate, the Ombudsman, the Equalities and Human Rights Commission, interested members of both chambers of Parliament) and seven voluntary organizations. Ethical approval for the research was obtained from the University of Sheffield.

All documents and interview transcripts were thematically coded and analysed in Microsoft Word using ethnographic content analysis (ECA). Unlike positivist document analysis, ECA conceptualizes document analysis as fieldwork and includes reflection upon document production. Reflexive and recursive movement between concept development—sampling—data collection—data coding—data analysis—interpretation provides a systematic approach, while retaining flexibility to (re)develop analytical categories (Altheide and Schneider, 2013). Based on this thematic analysis, I now explore prison regulation by voluntary organizations and bereaved families, involving (threats of) litigation. Pseudonyms are used throughout.

Case study: England and Wales

England and Wales is an informative case study for developing a theory of prison regulation. The UK actively participated in drafting OPCAT and was among the first to ratify it. The UK claims to have world-renowned detention monitoring methodologies and approaches, which it actively promotes overseas (NPM, 2016). England and Wales' large range of prison regulators serve as 'comparators for regulation elsewhere' (Van Zyl Smit, 2010: 509). Its prison regulation is among the densest public sector oversight formations (Hood et al., 1999: 116; Tomczak, 2018). Statutory regulators alone include: local Independent Monitoring Boards (1500 volunteers); the national Ombudsman and Inspectorate (which has a 'pervasive' influence and 'track record of principle-driven and independent' regulation (Van Zyl Smit, 2010: 555–556, 532)); 'relatively effective' regional monitoring by the European Court for Human Rights and the European Committee for the Prevention of Torture (Van Zyl Smit, 2010: 508); and international UN monitoring (Tomczak, 2018).

And yet, the UK's 'blueprint' detention monitoring apparatuses appear to have neither challenged imprisonment rates (with Scotland, England and Wales leading Western Europe (PRT, 2019: 56)) nor to have prevented recent dramatic declines in prison safety. Former Justice Secretary Chris Grayling's 2012 benchmarking policy generated historic staff reductions (Peacock et al., 2018). England and Wales' prisons have since become less safe than ever recorded, experiencing significantly elevated suicides, homicides, self-harm and assaults (PRT, 2019: 12). Between 2012 and 2016, suicide rates more than doubled, following 'workforce [. . .] efficiencies' (MoJ, 2016: 41). The record suicide numbers of 2016 harmed prisoners, staff and bereaved families, draining hundreds of millions of pounds from public funds (Tomczak, 2018). Record levels of self-harm followed: in 2017, 2018 and 2019 (MoJ, 2020; PRT, 2019: 13). These striking contradictions between the prevention of torture 'on the books' and in practice make England and Wales a particularly productive case study.

Multisectoral threats of litigation following multiple suicides

Threats of litigation from the voluntary sector and bereaved families have been erased from official narratives. Yet, my data demonstrate for the first time that their activities triggered both the *Corston report* (Home Office, 2007) on women with vulnerabilities in the criminal justice system, following multiple self-inflicted deaths at HMP Styal, and the 2015 *Harris review* on self-inflicted deaths in custody of 18–24-year-olds, following multiple self-inflicted deaths at HMYOI Aylesbury.

Corston followed the self-inflicted 'deaths of six women in Styal prison in Cheshire, England' (Moore et al., 2017: 1). Within 12 months spanning 2002–2003, these women ended their lives during their first month of imprisonment at Styal: Nissa Ann Smith (20 years old), Julie Walsh (39), Anna Baker (29), Sarah Campbell (18), Jolene Willis (26) and Haley Williams (41). The official narrative erased the actions of the voluntary sector and bereaved families:

> It is right that we continue to look at how the penal system treats women, and [. . .] what is most effective in preventing re-offending. It was for those reasons that [. . .] Home Office Minister Patricia Scotland, initiated a review of women with vulnerabilities in the criminal justice system in 2006, and asked Baroness Jean Corston to examine this.
>
> (MoJ, 2007: 2)

When someone dies by their own hands in prison, statutory provision for bereaved families comprises the prison Family Liaison Officer, who is responsible for assisting the family, albeit while potentially giving evidence and supporting prison staff at inquest (Harris, 2015: 167–168). Beyond this, support is provided on an ad hoc basis by voluntary organizations, primarily INQUEST: including gaining legal representation and often funding for it (Shaw and Coles, 2007: 41). Families are not automatically entitled to legal representation at inquests (Harris, 2015). Nevertheless, interview participant Sam explained how the work of voluntary organizations and bereaved families in threatening litigation stimulated *Corston*. As Whitty (2011: 129, emphasis in original) acknowledges, 'the mere *prospect* of prisoner litigation, with its attendant costs and unpredictability, is [. . .] a concern of organisational risk management':

> We were working on deaths [. . .] at Styal [. . .]. [We] worked closely with [. . .] families saying [. . .] there needed to be a public inquiry. So at the conclusion of the sixth of the inquests [. . .] Coroner Rheinberg [. . .] made a recommendation that [. . .] the six women's deaths, [. . .] they all had mental health and drug-related problems, warranted a more thorough inquiry. [. . .] That gave us [. . .] the recommendation that we could then campaign with [. . .] In terms of both the women's inquiry (*Corston*) and the young people's inquiry (*Harris*), always in the background was the [. . .] threat of litigation.
>
> (Sam, voluntary sector regulator)

Since *Corston*, voluntary organizations' and bereaved families' threatened litigation has translated a crisis centred on one specific institution, Styal prison, into a report that stimulated estate-wide discussion about provision for and treatment of female prisoners. The implementation of Corston's vision of local women's centres has been patchy and unsustained, but her report did bring important changes across the female estate; for example, ending routine strip-searching (INQUEST, 2018; WIP, 2017). Corston's conclusion: that jail was 'not the right place for many damaged and disadvantaged women' (Home Office, 2007: 69) influenced 2009's abandonment of 'Titan prison' plans (Bosworth, 2010: 254) and 2018's U-turn away from building women's prisons (Booth et al., 2018). Indeed, the number of women in prison has trended downwards ever since its 2008 high (PRT, 2019: 35). Despite criminological arguments that inquiries are ineffectual mechanisms for penal change (e.g. Razack, 2015; Scraton and Chadwick, 1986; Sim, 2019), the effects of *Corston* matter and provide a springboard for further activism.

Another set of deaths, this time in a young offender institution, HMYOI Aylesbury, near Oxford, led to the *Harris review* (Harris, 2015) on self-inflicted deaths of 18–24-year-olds in custody. Interview participant David explained how the work of voluntary organizations and bereaved families threatening litigation also stimulated *Harris*:

> To get themselves off a hook, [. . .] the hook they got on to was the mother of someone who had died [. . .] was taking the Ministry of Justice to judicial review on the basis of their refusal to have a public inquiry into [. . .] deaths of young people in custody. And that was on the basis of their failure to respond to recommendations from [. . .] *Fatally flawed*, by INQUEST and Prison Reform Trust (voluntary organizations), [. . .] that there should be a public inquiry into all these deaths because the same factors arose. [. . .] The MoJ [Ministry of Justice] decided they needed to be seen to do something and cheaper than having a public inquiry was [. . .] a major review.
>
> (David, statutory regulator, regarding *Harris*)

Publishing thematic reports such as *Fatally flawed* (PRT and INQUEST, 2012) and pressuring the Coroner to recommend an inquiry (as Sam described following deaths at HMP Styal) are themselves also potentially valuable state responsibilization strategies which might create impact and/or underpin future litigation, 'as claims of ignorance about a documented history of human rights violations will be less plausible' (Whitty, 2011: 133–134). However, Sam considered that actual threats of litigation were the decisive factor in bringing *Harris*:

> When we were working around deaths of young people it became clear that there had been [. . .] deaths in Aylesbury prison where the same recommendations had been repeated, where it was felt quite clearly that there was a potential litigation [. . .] Then the Prison Minister agreed to reconsider [. . .] if I am being honest I am sure it was the threat of litigation that pushed it, that's a reality but we then got *Harris*.
>
> (Sam, voluntary sector regulator)

My data demonstrate that voluntary organizations and bereaved families have increased the risks posed by prison suicide through threats of litigation, triggering at least two formal, official reviews (*Corston* and *Harris)*. Litigation actually brought in 2016 targeting a third prison, this time HMP Woodhill near Cambridge, correlates with prison staffing levels being dramatically increased across the estate, and Woodhill's first suicide-free calendar year *for seven years* in 2017.

Multisectoral litigation following multiple suicides at HMP Woodhill

Between May 2013 and December 2016, 18 prisoners took their lives at HMP Woodhill, near Milton Keynes in southern England (Tomczak, 2018). In November 2016, a judicial review was granted, having been brought by the bereaved families of former Woodhill prisoners Ian Brown (d. 19 July 2015) and Daniel Dunkley (d. 2 August 2016), with voluntary organization INQUEST intervening. The year 2017 then saw Woodhill's first calendar year without a suicide since 2010.

After nine years of recording between zero and two suicides annually, following Grayling's benchmarking, Woodhill recorded four suicides in 2013, two in 2014, five in 2015 and seven in 2016 (Shaw, 2017). These people died: Kevin Scarlett (aged 30),

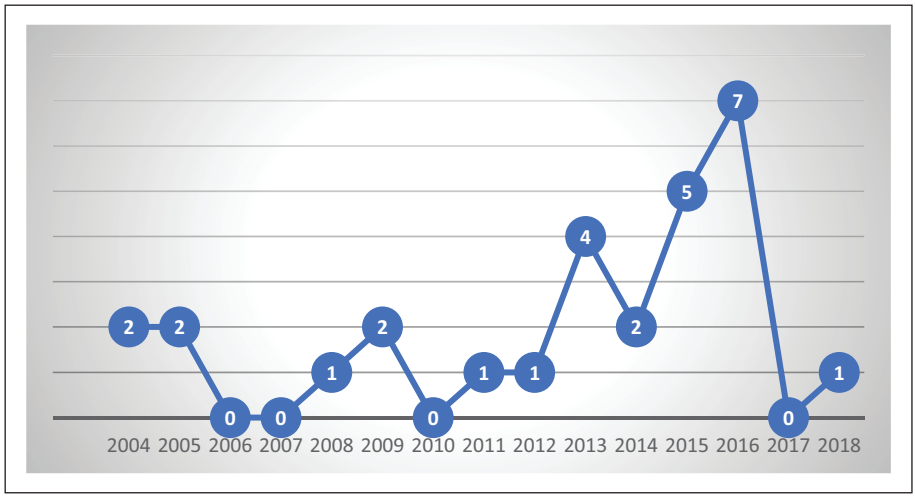

Figure 2. HMP Woodhill suicides.
Sources: Ombudsman fatal incident reports and Shaw (2017).

David Hunter (28), Sean Brock (21), Stephen Farrar (25), Dwane Harper (32), Jonathan White (37), Daniel Byrne (28), Ryan Harvey (23), Ian Brown (44), Joanne/Edward Latham (38), Simon Turvey (27), Ireneusz Polubinski (58), Robert Fenlon (35), Michael Cameron (45), Thomas Morris (31), Daniel Dunkley (35), David Reynor (41) and Jason Basalat (52).

Woodhill combines: (1) a local prison function, (2) a high security unit, holding around 17 Category A (high security) prisoners and (3) a close supervision centre for 'disruptive' prisoners (HMIP, 2015: 4). It combines these complex functions at the sharp end of prison staff cuts, with staff recruitment and retention particularly compromised by 'the cost of housing, and the number of alternative jobs both in Milton Keynes itself and (30 minutes away by the fastest trains) in London' (Shaw, 2017: 8). See Figure 2.

The judicial review challenged Woodhill's Governor and the Justice Secretary over failures to comply with duties to protect prisoners from suicide. Interview participant Sam explained the context:

> The frustration [. . .] has resulted in [. . .] a judicial review [. . .] You see the same issues repeating themselves time and again [. . .] out of almost desperation, we are thinking [. . .] if we can't get people to do something [. . .] then we will have to [. . .] use the Courts. [. . .] You can have the Prison Inspectorate, the Independent Monitoring Board, the Ombudsman, Coroner's Inquest, all pointing to issues and yet nothing happens.
>
> (Sam, voluntary sector regulator)

Although the Woodhill deaths were particularly acute, Sam's assertion that 'nothing happens' as a result of (statutory investigations into) prisoner deaths was supported across the estate by all but one of the statutory regulators interviewed. For example, Catherine

(statutory regulator) highlighted frustration that her statutory regulator was making repeated recommendations to no avail: 'We want to change [. . .] prisons and it is demoralizing when the numbers are going up and up and up and you are saying *the same things* over and over, [. . .] these are really important things and nothing's changing' (emphasis in original).

Chris (statutory regulator) described multiple (quasi-)statutory regulators, whom he characterized as minimally effective, and highlighted the economic costs of extensive (quasi-)statutory prison regulatory apparatuses: 'What's the role of [. . .] the usual suspects? Prisons Inspector, Prison and Probation Ombudsman. [. . .] There's all sorts of elements to the [. . .] governance picture, but I think [. . .] we spend lots of money on achieving very little.' Beverley echoed both Catherine and Chris, stressing repeated recommendations, questioning the efficacy of (quasi-)statutory regulators, and also expressing despair:

> The Ombudsman talked about the frustration of going back and finding the same mistakes. [. . .] The ministerial council on deaths in custody was in existence but how effective it was [. . .] I don't know. [. . .] With prisons, at that time [. . .] there was a lot of [. . .] public conflict between the Inspector and the government [. . .]. There is a point where you kind of go what is left? [. . .] The numbers keep going up, I certainly don't feel we have had a big impact.
>
> (Beverley, statutory regulator)

Statutory regulators highlighted lack of prison staff as a key reason for rising suicides at Woodhill and across the estate. For Catherine, recommendations were repeated because there were insufficient staff to deliver recommended practices:

> staff [. . .] have reduced and we are saying [. . .] speak to prisoners more, [. . .] there should be more care, more individualized attention to each prisoner, especially those at risk and how do you deliver that when you have got less people?
>
> (Catherine, statutory regulator)

Chris described how staff cuts had led to restricted regimes[10] and extended time in cell, which adversely affected prisoner well-being:

> If you can't get people out of their cell because there aren't enough prison staff. [. . .] If you haven't got staff then you haven't got control and [. . .] a colleague has been talking for a few years now about men being locked up for 23 hours a day [. . .] how can you not go mad, how can you not be out of your mind in that situation? [. . .] So yes people are dying and it seems perfectly explainable to me. [. . .] There is not enough staff to keep people safe.
>
> (Chris, statutory regulator)

Staffing problems evident at Woodhill, and less acutely elsewhere, had been rigorously documented for multiple years by numerous statutory regulators (Tomczak, 2018), although had not stimulated any response. Woodhill's Independent Monitoring Board (IMB, 2014: 6) reported: from 'mid 2013 the regime was reduced [. . .] staff shortages

have resulted in compromises to the [. . .] regime and reduced time out of cell'. By 2017, Woodhill had functioned with restricted regimes for three entire reporting years. Serious staff shortages had 'only worsened', leading to prisoner boredom and isolation, which form 'major contributing factors in the increase in [. . .] self harm' (IMB, 2017: 4).

In January 2014 the Inspectorate visited Woodhill and noted enduring lack of purposeful activity; self-harm incidents almost double comparators'; five suicides since the last inspection and a lack of response (HMIP, 2014: 5). In September 2015 the Inspectorate again reported long waits to see the mental health team due to staff shortages, very long waits for transfer to hospital and residential staff ill-equipped to deal with mental health problems (HMIP, 2015: 5–6). The Ombudsman investigated each Woodhill death, repeating serious concerns, for example: 'There had been little effective implementation of previous recommendations about identifying risk and little evidence of staff engagement with Mr Turvey in the six months he was at Woodhill' (PPO, 2016). The Coroner for Milton Keynes sent multiple Reports to Prevent Future Deaths [To the Prisons Minister]: 'a Governor [. . .] informed me that the number of prison officers at HMP Woodhill had recently been reduced by one third. The reduction in numbers will in his view compromise prisoner safety' (Osborne, 2014). The National Offender Management Service (NOMS, 2014) replied: the 'staffing forecast includes an agreed complement of Officers that are necessary to provide decent and secure conditions'.

Regional and international regulators did not visit Woodhill itself but raised allied concerns. The European Committee for the Prevention of Torture visited the UK in April 2016 (Council of Europe, 2017: 7). They recommended that:

> concrete and effective measures to address the lack of safety [. . .] in English adult prisons and the youth estate be prioritised. These should include urgent measures [. . .] reversing the recent trends of escalating violence, self-harm and suicides; (and) concrete steps to significantly reduce the current prison population.
>
> (Council of Europe, 2017: 29)

The UN Human Rights Committee's 2015 report noted 'the increased number of suicides in custody [. . .] and other cases of self-harm', recommending 'robust' prevention measures (UNHRC, 2015: 7). Nevertheless, the Woodhill spate and rising suicides across the prison estate continued amid vigorous critique from regulators at local, national, regional and international levels.

The judicial review brought by two families bereaved at Woodhill, with voluntary organization INQUEST intervening, was granted in November 2016. By February 2017, Justice Secretary Elizabeth Truss had announced NOMS's rebranding to Her Majesty's Prison and Probation Service and a 'boost' of frontline staff (MoJ, 2017), and the Ministry of Justice had commissioned the *Shaw review* of Woodhill's suicide and self-harm prevention. Although 'the commissioning note makes no mention of the Judicial Review [. . .] it is not in doubt that [. . .] was the precipitating factor' (Shaw, 2017: 6). Shaw (2017: 11–14, 38) highlighted:

> the lack of consistent staffing. [. . .] Regularly at night there were insufficient staff to unlock a prisoner in distress. [. . .] The combination of reductions in the complement and difficulties of

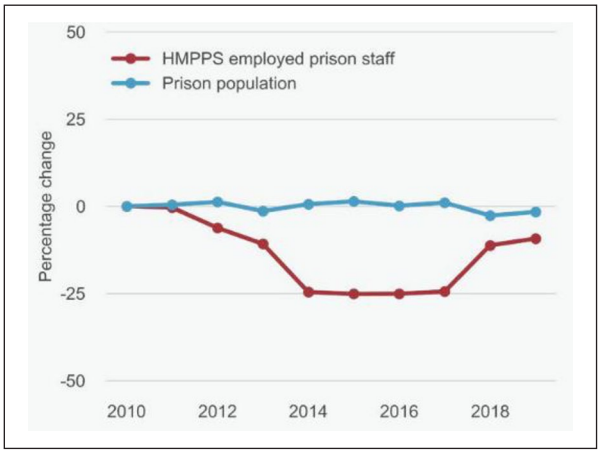

Figure 3. Public sector prison staff and the prison population.
Source: PRT (2019: 17).

> recruitment and retention have resulted in a completely unacceptable situation at Woodhill. These staffing pressures have been allowed to persist for far too long.

These very staffing problems had been documented by multiple statutory regulators for years, but apparently did not matter to decision makers until the judicial review was granted, in turn realizing legal and organizational risk for the state (Whitty, 2011). Shaw (2017: 36) provided estate-wide critique that suicide prevention policies were 'designed at a time when the number of staff in prisons was significantly higher [. . .] and [. . .] the prison population was significantly lower'. Following Prison Instructions regarding suicide prevention procedures was therefore an: 'impossibility in Woodhill [. . .] This will apply to the vast majority of prisons. [. . .] It is not healthy for what is practicable to diverge so wildly from what is described as a mandatory action' (Shaw, 2017: 36).

The judicial review was ultimately unsuccessful in the courts in May 2017, on the basis that the high number of operational mistakes in suicide prevention at Woodhill did not represent systemic failure but had been different in each case. However, in 2017 Woodhill had its first suicide-free calendar year *for seven years*. It is highly problematic that litigation by the voluntary sector and families, who had already endured police, Ombudsman and Coroner investigations into their relatives' deaths was required to create a response to rising suicides (Tomczak, 2018). Nevertheless, England and Wales' prison population subsequently fell to its lowest level for a decade. The prison population on 25 November 2016 was 84,976, at rate 147/100,000 (PRT, 2016). By 23 November 2018, the population was 82,888 at rate 141/100,000 (PRT, 2018). Between March 2017 and 2018, prison suicides fell from 115 to 73 (MoJ, 2019). Staff cuts were partially reversed, as Figure 3 illustrates.

Although severe problems endure, it is important to acknowledge that strategic litigation by the voluntary sector and bereaved families effectively provided escalating sanctions, stimulating some response to declining prison safety and exercising more powerful regulation than the state bodies that form scholars' usual focus.

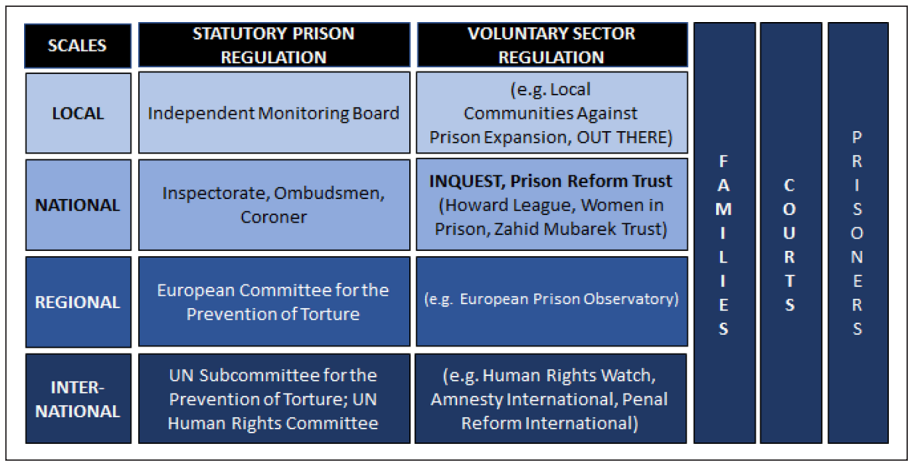

Figure 4. (Potential) multiscalar, multisectoral prison regulation.

Conclusion

In this article, I have advocated sustained development and empirical testing of multiscalar, multisectoral prison regulation theory. My argument has implications across the (criminal justice) institutions which feed imprisonment, although policing, courts, community supervision and psychiatric detention are beyond the scope of this article. In England and Wales, statutory prison regulators depend on persuasion as they lack escalation, sanctioning or enforcement abilities (Hood et al., 1999). This includes the Inspectorate's new 'urgent notification' protocol (Tomczak, 2018). The absence of escalation abilities forms 'a significant gap from the perspective of regulatory theory' (Seddon, 2010: 266) as regulatory enforcement requires an escalating pyramid of sanctions (Ayres and Braithwaite, 1992). Courts can escalate sanctions, but cases must be brought to them. We must look 'beyond the usual suspects' and recognize that 'a great deal of very potent regulatory activity is the work of institutions and actors independent of the state' (Grabosky, 2013: 120), which can be usefully informed by processual social ontology.

I have illustrated how voluntary organizations and bereaved families act by threatening and bringing litigation, which can regulate imprisonment. In turn, this challenges accounts of responsibilization by the state, indicating that multisectoral actors can transcend conventional regulatory landscapes of fixed distances between actors and exert an influence and reach way beyond their means and resources. Without looking beyond state-centric prison regulation (e.g. the Inspectorate, Ombudsman) and being open to the potential for state carceral power to be disrupted, the stimuli for *Corston, Harris* and the 2017 overturning of severe cuts to prison staff through benchmarking could have remained invisible. Figure 4 sketches a broader conceptualization of prison regulation, developing the local and national regulation explained in my analysis. These multisectoral actors could form denser vertical and horizontal

networks of prison regulation and advance issue-based prison regulation by working together (Braithwaite et al., 2007b).

The potential of litigation alone to improve conditions within, dismantle or constrain the neoliberal carceral state should not be overplayed (Gottschalk, 2006). Voluntary organizations too often provide the state's services and run programmes which responsibilize already marginalized individuals (Tomczak and Buck, 2019b). We have not yet conceived political forms that will stop the creation of garbage-can populations (Khanna, 2009) that can be disposed of in prison. Nevertheless, ignoring trends pointing in a different direction is itself partial and problematic (Carlen, 2001; Zedner, 2002), and lives are literally at stake.

Scholars have illustrated that penal change is the product of struggle between actors with different types and amounts of power (Carlton, 2018; Gottschalk, 2006). Rethinking prison regulation presents new possibilities to mediate conditions and rates of imprisonment, which require further exploration. Prison regulation could involve (1) multisectoral collaboration across stakeholder groups, (2) across interest areas (e.g. justice, social policy, social work (Garrett, 2016), health (McLeod et al., 2020)); (3) drawing on the people (working) in all of these groups (e.g. Cummins, 1994; Goodman et al., 2015); (4) and operating across scales to achieve jointly desired outcomes. Such outcomes could include improving prison safety for the benefit of societies, prison staff and prisoners. As such, this article contributes to the essential task of reinstating analytical (and social) power over neoliberal inevitability within and beyond detention settings (Bosworth, 2011).

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ORCID iD

Philippa Tomczak https://orcid.org/0000-0002-2347-2479

Notes

1. Regulators differentially prioritize *prevention* of ill-treatment and *responses* to it. OPCAT is principally preventative, while retrospective prison oversight (e.g. complaints, prisoner death investigations) might be termed 'accountability' (Mashaw, 2006). Regulation is essentially prospective while accountability is essentially retrospective (Black, 2001), although it is often unclear where regulation ends and accountability begins. Fair and effective social processes require both regulation and accountability (Smith, 2009). Sapers and Zinger (2010: 1515) demonstrate this hybrid, regarding the Canadian Office of the Correctional Investigator's (Federal Prison Ombudsman) dual roles: providing redress for individual grievances

(accountability) and stimulating the improvement of standards (regulation).
2. Ninety states party at the time of writing, plus 13 signatories. See https://www.ohchr.org/Documents/HRBodies/OPCAT/StatRatOPCAT.pdf (accessed 18 February 2020).
3. Future work should also examine the multiscalar *targets* of regulation: for example, individual prison staff, individual prisons, responsible ministers and policymakers, international formations.
4. Cliquennois and Champetier (2016: 93) critiqued NGOs bringing cases against the Russian Federation specifically before the European Court of Human Rights, highlighting that private litigation funding amounts to a 'new cold war'.
5. R (Howard League and The Prisoners' Claimants Advice Service) COURT OF APPEAL (CIVIL DIVISION), [2017] EWCA Civ 244.
6. The Howard League's landmark 2002 judicial review of children's human rights in Young Offender Institutions found that Prison Service Order 4950 'Regimes for Juveniles' was wrong in law (Owen and Macdonald, 2015: 499) and 'a local authority retains a statutory duty to safeguard the welfare of children [. . .] in custody' (Valier, 2004: 20). This illustrated that legal strategies can contest penal policy, and media interest surrounding the case 'made visible' policy effects on prisoners (Valier, 2004: 24).
7. *R v Jogee* [2016] UKSC 8. Voluntary organization Just for Kids Law intervened in this case.
8. Suicide is 'the termination of an individual's life, resulting directly from a negative or positive act of the victim himself, which he knows will produce this fatal result' (Durkheim, 1952: 44). But intention in completed self-inflicted deaths is often unclear, and confused and mixed intentions can be seen in custodial deaths (Walker and Towl, 2016: 31).
9. See https://www.ppo.gov.uk/document/fii-report/; https://www.judiciary.gov.uk/subject/state-custody-related-deaths/ (accessed 18 February 2020).
10. Amended prison timetables which can involve cancelling everything except meals and medication.

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Author biography

Philippa Tomczak's research interests include the regulation of detention rates and conditions, prison suicide, deaths in criminal justice detention, the penal voluntary sector and emotion in voluntary sector practice. She co-ordinates the *Prisons, Health and Societies* research group.