Event Report

Learning across death investigations

Wednesday 11th – Thursday 12th September 2024
Manchester Art Gallery, England

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Introduction

The *Learning from Death Investigations* event took place at Manchester Art Gallery from 11th – 12th September 2024, drawing together people who have worked on different types of death investigations. The event sought to assemble academic experts from multiple areas of inquiry and was attended by academic researchers and practitioners from Australia, England and Scotland working in criminology, forensic medicine, social sciences, health sciences, social work and social care, gender and equalities, psychology and safeguarding.

Summary of event content: Day One

Professor Philippa Tomczak, University of Nottingham, opened the event, introducing her work on prisoner death investigations through two policy briefs. The first highlighted how inaccurate recording of prisoner deaths means we cannot properly identify points of prevention (Tomczak and Mulgrew, 2023). The second highlighted how formal investigations after a death in prison (including those by coroners and the prison and probation ombudsman) have huge social, emotional and financial costs, but often fail to get 'to the heart' of problems, focusing on staff members' policy compliance rather than enduring systemic hazards (Tomczak et al., 2023). She asked the group to consider if any of these points resonate in their areas.

Dr Lyndal Bugeja, Monash University, provided the keynote international provocation, focusing on recommendations following a death in custody in New South Wales, Australia. Lyndal highlighted disproportionately high Aboriginal deaths in custody, which have been the focus of social protest, civil society monitoring and national inquiries. When recommendations are made following deaths, they are not always implemented, nor do they impact death rates. There can also be issues with the availability and quality of death data in Australia (Truong et al., 2023). The group reflected on broader inequalities, colonialism and ways to analyse harmful silences in data.

Professor Sara Ryan, Manchester Metropolitan University, examined coronial processes involving families of autistic people, people with learning disabilities and/or mental ill health. Drawing on interviews with people who had been through coronial processes, she highlighted how families frequently experience a kind of epistemic injustice (Fricker, 2007), being disbelieved, and marginalised from processes and learning, rather than being 'at the heart'. Sara challenged assumptions that death investigations provide families with catharsis or are an effective way of holding stakeholders to account. She called for more humanity in learning processes and more openness to families' knowledge of the person who has died. She has also called for more qualitative research to better understand bereaved family experiences of inquiries and investigations (Ryan, 2019).

Dr Alex Murray, Birkbeck University of London, discussed the involvement of bereaved people in coronial investigations. Drawing on the Voicing Loss project, Alex highlighted how the Coroners and Justice Act 2009 aimed to enhance the status and inclusion of bereaved people, but there can be tension between what families want and what happens technically. For example, people often expected lesson-learning and accountability, but lesson-learning was often ancillary to the main inquest aim of fact-finding. There is variety in coroner's hearings and the meeting of families' expectations is inconsistent. Inquests can also be harmful if people feel disadvantaged by the process, indicating a need to better support bereaved people, put humanity at the heart, and develop improved provision beyond coroners, such as restorative justice.

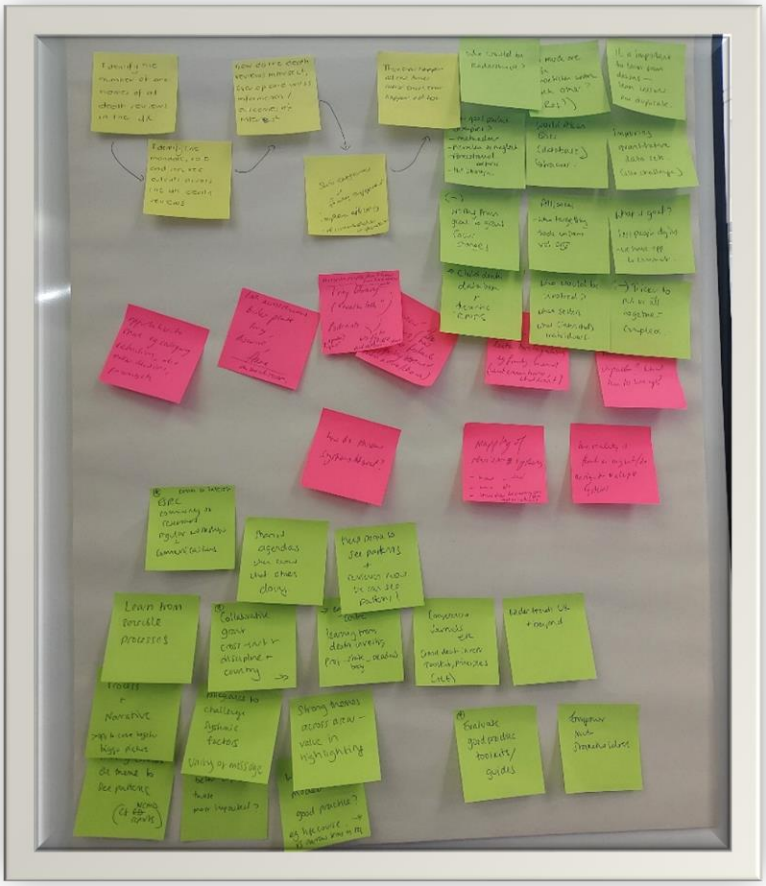
Professor Carlene Firmin, Durham University, explored the extent to which Serious Case Reviews (SCRs), now called Child Safeguarding Practice Reviews (CSPRs), identify contextual drivers of harm. Carlene introduced research into deaths involving extra-familial harm and noted that reviews were more likely to locate local shortfalls rather than national failings. For example, nationally there is no ethical advice on sharing information about young people's friendships. Sources of safety were also often *not* noted, as contextual features were viewed through a lens of risk and there is often a lack of information provided to professionals in terms of implementing required practice changes.

Dr Joanna Garstang, University of Birmingham, introduced the National Child Mortality Database which gathers information on all children who die in England to save children's lives in the future. The database aims to capture, analyse and disseminate data and learning from child death reviews. It enables the analysis of patterns and risk factors to target preventative health and produces toolkits to help families understand processes following a death. Most deaths of children result from health needs rather than safeguarding issues. Child death reviews take place for every child in England, Wales and Scotland. Reviews are multi-agency, and a key worker represents the views of families. Emotional resilience is required to work in this area and review themes.

Dr Ray Jones, **Kingston University,** discussed reviews and inquiries following the deaths of children and of disabled adults, noting three 'big Cs': context, collaboration, and consequences. In terms of *context*, reviews are huge in number. There has been an average of 150 serious case reviews per year since 1990, each averaging 30 recommendations. A total of approximately 180,000 recommendations have constipated organisations and paralysed workers. There is a need to look at governance, management culture and how managers can be enabled to hear when things are/ are not going well. In terms of *collaboration*, currently a lot is done *to* workers and agencies, but coproduction can be empowering. People need to have trust to come forward and build the story as they understand it. Finally, *consequences*, something must happen. When we learn from deaths, how can we ensure changes are shared nationally?

Collaborative workshop

Following the first day's lighting provocations, attendees were invited to work together in small groups to consider in if scholarship, practice and learning about different kinds of death investigations *should* be linked and what links, if any could be helpful.



Group 1 noted potential for collaborative (cross disciplinary, cross sector) grant applications to explore what a 'good' death investigation looks like, opportunities to co-produce toolkits and good practice guides in different areas and potential to learn from multi-stakeholder inquiries which hold families as central (e.g., the Hillsborough inquiry). ***Group 2*** noted there may be value in identifying of all death reviews in UK, e.g., by name, mandate, role, outputs. This could assist with identifying intersections, overlaps, areas of missed opportunity and potential alliances. Grouping reviews with purpose could also create subcategories of recommendations. ***Group 3*** noted the potential to make resources (e.g., living libraries, podcasts, experiences of death investigations, how families can navigate systems), being clear about language and how we define things. It may be valuable to understand the full monetary cost of reviews and where cost may outweigh benefits. Also to understand the drivers for review systems being set up, what sustains them and how their recommendations are formulated.

Summary of content: Day Two

Dr Georgia Richards**,** Kings College London, introduced the Preventable Deaths Tracker, a data-driven tool that monitors deaths reported by coroners. In England and Wales, coroners are mandated to produce a Prevention of Future Deaths (PFD) report when they believe that action should be taken to prevent deaths. Individuals or organisations that receive a PFD report are required to respond within 56 days and outline proposed actions (Richards et al., 2021), but there is little monitoring and only 50% respond. Georgia explained how the tracker seeks to improve data monitoring for lesson learning. She shared her work on the tracker with the Justice Committee, who amplified her recommendations to improve the IT system for PFD reporting and responses and use nationally standardised templates and death categories to improve the quality of data.

Dr James Rowlands, Durham University introduced Domestic Homicide Reviews (DHRs), which were renamed Domestic Abuse Related Death Reviews (DARDRs) in 2024. These reviews have been a statutory requirement since 2004 and James shared the national library, which seeks to help identify lessons, prevent further domestic abuse and improve services for victims. Despite these ambitions, James noted a complicated map of activity involving multiple stakeholders and commissioners, a lack of robust national oversight and limited evidence of learning from other statutory review systems. He posed provocations to the audience including: How can we drive the DARDRs system most effectively so it can deliver its ambitions? Is the state the best owner for the DARDRs? What are the opportunities to learn from other statutory review systems?

Professor Khatidja Chantler, Manchester Metropolitan University, provided an analysis of DHRs, now DARDRs. She noted how a life course analysis is currently lacking. Whilst there is a huge policy focus on families with children, in 70% of homicides there were no children living in the home. In nearly three-quarters of cases there was abuse in the relationship prior to the homicide. Family members, and agencies (most commonly police and health) were aware of the abuse in nearly two-thirds of cases yet only 11% of homicide cases had been reviewed at a Multi-Agency Risk Assessment Conference (MARAC). System level changes are required, including improved multiagency safeguarding, and strengthened responses to Black and minoritised victims given domestic abuse is too often framed as endemic to minoritised cultures, impacting trust and confidence in public services (Chantler et al., 2023). Khatidja also signposted the HALT website, which includes films about how families experienced review processes.

Dr Sarah Huque, University of Edinburgh, provided an analysis of suicide reviews in Scotland. Sarah introduced the Suicide Cultures study, a sociologically informed, multi-disciplinary project exploring understanding of suicide across Scotland. Using a ‘sociological autopsy’ approach the team analysed 300 NHS and multi-agency reviews and found that social scripts about suicide inform review processes, for example, the deaths of older people are seen as more acceptable, suicides in prison are constructed as ‘inevitable’ and/or ‘unforeseeable’, absolving the prison of blame and responsibility. Sarah posed

‘challenging questions’ for reviews including whether there is an over-reliance on certain (statutory) types of data and if the focus could be de-individualised to enhance contextual and systems learning.

Next steps

To continue the connections made and discussions started, Dr Elizabeth Cook and Dr James Rowlands proposed a follow on one-day conference in April 2025. If you would like to suggest areas of focus or join the organising committee, please email Elizabeth.Cook@city.ac.uk or james.h.rowlands@durham.ac.uk

Conference feedback

“This workshop brought together a range of professionals, practitioners and academics involved in reviews of preventable deaths. It was a valuable opportunity to share findings and opportunities to strengthen the outcomes of deaths reviews across the UK and internationally. Many thanks to the team for bringing this group together”

“The event was a great opportunity to start a dialogue between different statutory review systems, and the shared challenges and opportunities of this work”

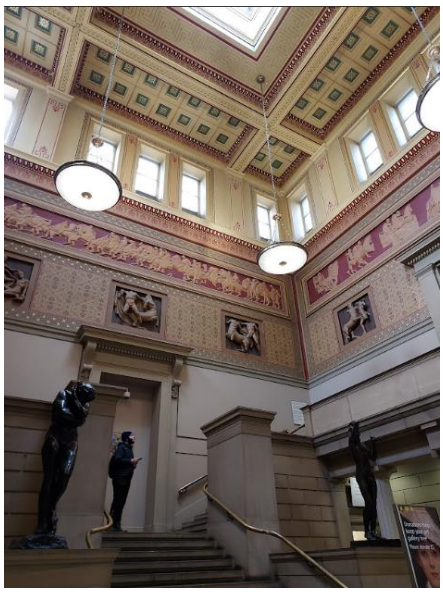
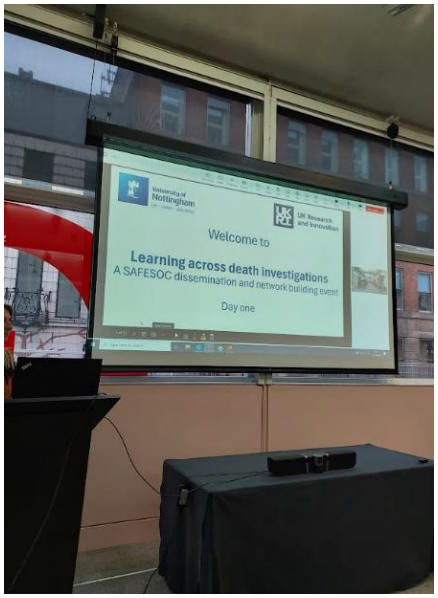
“This event was a really unique glimpse into the huge variety of work being done on reviews and an opportunity to think about the implications of our work collectively”

“It was a privilege to be in the same room with a group of academics, professionals and others, committed to social justice and, in particular, improving death investigations”.

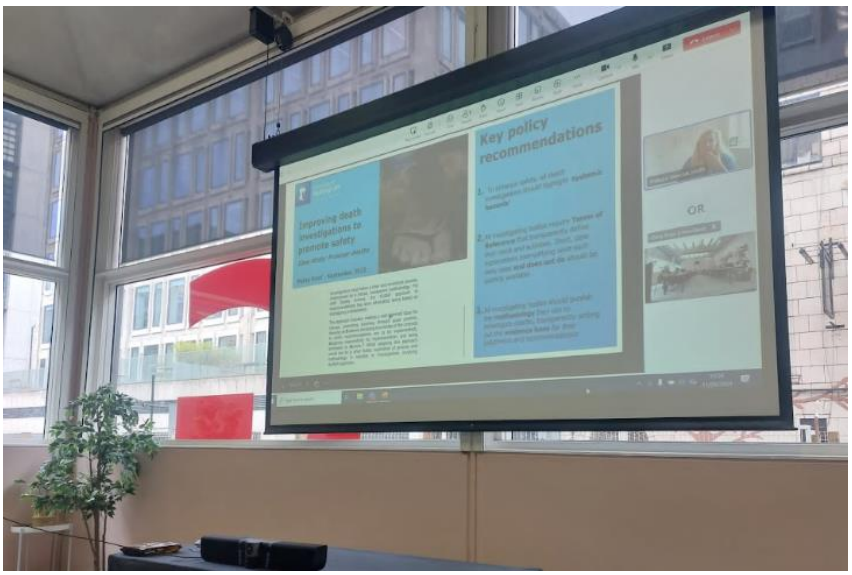
“It is so valuable to step outside of your day-to-day conversations and think about the wider strategic implications of your work and have opportunities to pursue them – this conference did just that”

“This was my first in-person event since before the pandemic and I was quite nervous. Everyone was very lovely, the organisation of the event was perfect and I had a great time.”

Photographs from the event

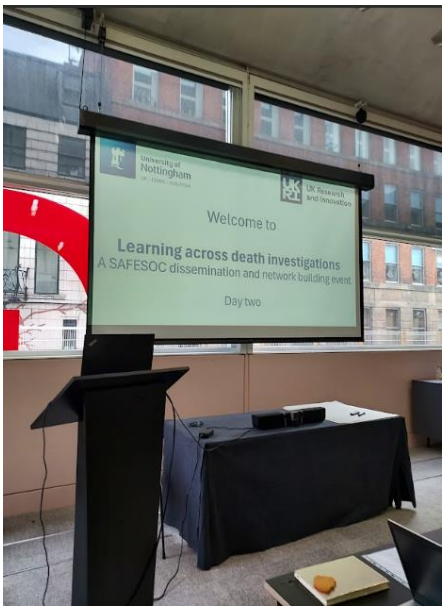



Manchester Art Gallery



Philippa Tomczak's opening address

Lyndal Bugeja's international address



Georgia Richards' Preventable Deaths Tracker

University of Nottingham
UK | CHINA | MALAYSIA

UK Research and Innovation

AGENDA

Learning across death investigations

A SAFESOC dissemination and network building event

11-12 September 2024. Manchester Art Gallery, England

Day 1 – Wednesday 11 September 2024 – 9.30am - 16.15pm

	Time	Title & Speaker
Registration and Welcome Coffee	09.30 – 10.00	
Opening Address	10.00 – 10.30	Opening Address: Linking death investigations to promote safety **(Professor Philippa Tomczak - University of Nottingham, Dr Gill Buck -University of Chester)**
International provocation	10.30 – 11.00	International provocation: Recommendations following a death in custody (**Dr Lyndal Bugeja – Monash University, Victoria, Australia)**
Questions and discussion	11.00 – 11.20	All attendees
Break: 11.20 - 11.40 (refreshments)		
Speed networking	11.40 – 12.30	Participants introduce self and research interests for 1 min each
Lightning provocations (3 x 10 mins)	12.30 – 1.15	Emphasis on clarity, brevity, diverse audience: 1) Between epistemic injustice and therapeutic jurisprudence: coronial processes involving families of autistic people, people with learning disabilities and/or mental ill health (**Professor Sara Ryan – Manchester Metropolitan University**) 2) Humanity at the heart: the involvement of bereaved people in coronial investigations (**Dr Alex Murray – Birkbeck University of London**) 3) Safeguarding Adult reviews (**Professor Paul Kingston – University of Chester**) Questions and discussion
Lunch: 13.15- 14.15		
Lightning provocations (3 x 10 mins)	14.15 – 15.00	1) Do serious case reviews identify contextual drivers of harm? **(Professor Carlene Firmin – Durham University)** 2) Child Death investigations and the National Child Mortality Database (**Dr Joanna Garstang – University of Birmingham**) 3) Independent inquiries following the deaths of children and of disabled adults (**Dr Ray Jones – Kingston University**) Questions and discussion
Collaborative workshop	15.00 – 16.00	Next steps and ideas for collaborative work / research / writing
Closing remarks and reflection	16.00 – 16.15	
Dinner at The Fountain House: 19.00		

Day 2 – 12 September 2024 - 9.00 - 13.15

	Time	Title & Speaker
Arrival and Coffee	**9.30 – 10.00**	
Day two welcome	**10.00 – 10.10**	
UK provocation	**10.10 – 10.40**	Preventable Deaths Tracker tool (**Dr Georgia Richards – Kings College London**)
Lightning provocations (3 x 10 mins)	**11.00 – 12.05**	1) Domestic Homicide Reviews in practice (**Dr James Rowlands – Durham University**) 2) An analysis of domestic homicide reviews (**Professor Khatidja Chantler – Manchester Metropolitan University**) 3) An analysis of multiagency and NHS suicide reviews in Scotland **(Dr Sarah Huque – University of Edinburgh**) Questions and discussions
Closing remarks	**12.05 – 12.15**	Launch of Death investigation learning hub: collaboration beyond conference
Lunch: 12.15 - 13.15		