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DETENTION MONITORING TOOL

Deaths in prison

A guide for detention monitors

Deaths in prison: a tool for detention monitors

This document is produced by Penal Reform International (PRI), supported by the University of Nottingham. PRI would like to thank the following for their contribution to the report: Morris Tidball-Binz, United Nations Special Rapporteur on extrajudicial, summary or arbitrary executions, Rafael Barreto Souza Crime Prevention and Criminal Justice Officer (Prison Reform), United Nations Office on Drugs and Crime, and Ksenia Žurakovskaja-Aru, Senior adviser, Office of the Chancellor of Justice, Republic of Estonia. This work was supported by funding to Prof. Philippa Tomczak from UK Research and Innovation [grant number MR/T019085/1] and the University of Nottingham.

Penal Reform International

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Published in May 2025

Cover photo: The contact visitation area at a correctional centre near Brisbane, Australia. Cory Wright.

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Context

People die in prison from a multitude of causes including non-communicable and communicable diseases, torture and other forms of violence (including inter-prisoner violence) and suicide. Furthermore, environmental factors such as overcrowding, poor conditions of detention and inadequate access to healthcare ultimately lead to fatalities by exacerbating health conditions or causing disease.

Mortality rates are up to 50% higher for people in prison than for people in the wider community.[1] This raises serious concerns for the protection of human rights, public health, and prison management.

States bear a heightened responsibility for people in prison because when they deprive someone of their liberty, they assume a duty of care to protect the right to life. As part of this, there is an obligation to report and investigate deaths in custody, as well as disappearances and serious injuries. States must do this to prevent violence and ill-treatment in prisons and ensure that conditions of detention meet international human rights standards, such as providing healthcare equivalent to that available in the community.

Detention monitoring bodies, including National Preventive Mechanisms (NPMs), National Human Rights Institutions (NHRIs), regional and international bodies, civil society and the media, have a critical role in bringing greater scrutiny to the investigation of deaths in prison and preventing them in the first place.

This guide for detention monitors can be used alongside these resources:

- Penal Reform International and *prison*DEATH, **Investigating deaths in prison: A guide to a human rights-based approach**, 2023
  www.penalreform.org/resource/investigating-deaths-in-prison-a-guide
- Penal Reform International and prisonDEATH, **Deaths in prison: Examining causes, responses and prevention of deaths in prison worldwide**, 2022
  www.penalreform.org/resource/deaths-in-prison-examining-causes-responses-and-prevention
- University of Nottingham and University of Galway, **Improving prisoner death statistics**, Policy Brief, October 2024
  safesoc.z6.web.core.windows.net/index.html@p=986.html
- University of Nottingham, **Improving death investigations to promote safety**, Case study: Prisoner deaths, September 2023
  safesoc.z6.web.core.windows.net/index.html@p=986.html
- **Report of the UN Special Rapporteur on extrajudicial, summary or arbitrary executions**, Morris Tidball-Binz, April 2023
  www.ohchr.org/en/documents/thematic-reports/ahrc5329-deaths-prisons-report-special-rapporteur-extrajudicial-summary

1. UN Human Rights Council, Human rights in the administration of justice: Report of the United Nations High Commissioner for Human Rights, A/HRC/42/20, 21 August 2019, para. 30.

Data

Data remains a key problem in understanding the causes of and addressing deaths in prisons. Public availability of accurate and reliable data on incidents of deaths and violence in prisons (and police detention) is key, in the interest of transparency and facilitating effective investigations.[2] However, a significant concern is the number of deaths occurring outside of prisons, such as in hospitals. In some jurisdictions, this figure may be notably higher or, in some cases, exceed the number of deaths in prisons, such as in Albania, Belgium, Georgia, Greece and Turkey.[3]

Deaths of prisoners may result from a complex interplay of medical, legal, environmental, and structural issues. Misclassification of deaths, whether by oversight or design, remains a critical issue, undermining accountability, impeding accurate data collection and meaning that responsibility for prison deaths frequently goes unexamined. For instance, cases where homicides are erroneously classified as suicides exemplify the serious consequences of such misclassification.[4]

Part of the issue with a lack of data is that jurisdictions categorise prison deaths differently, making comparative analysis difficult.

Deaths are recorded under broad terms like 'natural causes', without uniform criteria. This catch-all term includes deaths due to age, illness, or cardiovascular disease but lacks a precise definition. This can obscure the underlying reasons for deaths such as poor detention conditions, ill-treatment or lack of adequate healthcare. Labelling deaths as 'natural causes' often fails to address the challenge of inadequate healthcare infrastructure and the barriers to access healthcare, with young people sometimes dying from treatable illnesses like pneumonia. It also casts a shadow over unrecorded homicides.

'Non-natural' deaths encompass deliberate harm, including homicide, suicide, accidents, drug-related deaths, and those linked to excessive force or abuse. Initial classifications of deaths are often 'undetermined', awaiting thorough investigation.

Tenets for prisoner death data

Developed jointly by the Universities of Nottingham (England) and Galway (Ireland)[5]

Comprehensive data collection: Record all prisoner deaths, including those outside prison facilities, with clear, verified details on the specific cause and manner of death.

Disaggregated data: Include identifiers like gender, race, age, ethnicity, sexuality, disability, and legal status to identify which prisoners died, as required by human rights standards.

Contextualised information: Provide detailed context about each death, noting factors such as drug involvement, sexual violence, the use of restraints or weapons, the location of death, custody status (pre-trial or sentenced), and whether mass fatalities or mass perpetrators were involved.

Another challenge is that methods for determining causes of prisoner deaths—such as autopsies, medical reviews, and legal inquests—differ widely between countries, making comparison challenging and limiting potential for learning across jurisdictions, thereby impeding efforts to improve investigative standards globally.

Transparency plays a crucial role in ensuring accountability within prison systems for preventable deaths and informing evidence-based decision-making. Data needs to be made publicly accessible for analysis, research and identification of recurring issues. Transparent reporting at national and international level is essential for maintaining public trust and ensuring that systemic problems within the prison system are continuously addressed.

2. University of Nottingham and University of Galway, Improving prisoner death statistics, Policy Brief, October 2024, https://safesoc.z6.web.core.windows.net/index.html@p=986.html
3. Ibid.
4. Tomczak, P., & Mulgrew, R. (2023). Making prisoner deaths visible: Towards a new epistemological approach. Incarceration, 4, 26326663231160344.
5. University of Nottingham and University of Galway, Improving prisoner death statistics, Policy Brief, October 2024, https://safesoc.z6.web.core.windows.net/index.html@p=986.html

DETENTION MONITORS SHOULD:

- **Evaluate the data systems on prisoner deaths, both at a facility- and centralised-level, to enhance national and international learning and collaboration, thereby maximising the potential for lifesaving improvements.**
- **Provide analysis and recommendations for improving the data on prisoner deaths, in line with the 'Tenets for prisoner death data' (see box).**
- **Assess the level of transparency of prisoner deaths' data, including the level of disaggregation and accessibility.**
- **Assess how prisoner deaths are classified, giving recommendations to improve definitions and classification methods including to remove broad terms.**
- **As far as possible, delve into details of individual prisoner deaths' records to verify accuracy and completeness. For example, visit the morgues, review forensic reports and medical documentation, including incident records, medical appointments, etc. and speak with families, prisoner support networks and peers to understand the context in which someone has died. This approach has been adopted, for instance, by the National Preventive Mechanism in Brazil.[6]**

6. See: www.sindiperito.org.br/noticias/2023/4/13/iml-to-recebe-visita-de-integrantes-do-mecanismo-nacional-de-prevencao-e-combate-a-tortura-acompanhados-pelo-presidente-do-sindiperito-silvio-jaca-tambem-foram-recebidos-no-gabinete-do-deputado-moisemar-marinho/.

Responses and investigations

Immediate responses

Every prison system should have a comprehensive regulation system in place outlining the necessary steps if a death occurs in prison, regardless of the cause. The body and the location where the deceased is must be immediately secured to preserve all evidence, bearing in mind it may be a crime scene. If any wrongdoing is suspected, whether by a staff member, another detainee, or other person, they should be separated from others, protected from any possible reprisal and all relevant information provided to the investigating authority.

Bereavement when a loved one dies in prison is particularly distressing and traumatic for families. It is essential that families are informed immediately of the death and that they are treated with respect, sensitivity and transparency by authorities at all times.

DETENTION MONITORS SHOULD:

- **Assess the existence and adequacy of regulations and rules, as well as training for prison staff on prison deaths**
- **Examine the processes (including the prison records, daily logs and incident reports) in place and practices around any prison death with regards to informing the relevant investigatory authorities**
- **Assess the communication and support policies and practices for peers and staff in prisons in the case of a prisoner death**
- **Make recommendations for the improvement of the policies, practices and training thereof regarding all aspects for prison management and staff, including on immediate necessary steps after a death, processes on informing the next of kin of the death and support available, the preservation of any evidence, etc.**

The UN Nelson Mandela Rules

The UN Nelson Mandela Rules requires prison authorities to:

1. Record the cause and details of any such death and promptly inform the next of kin

2. Treat the remains of the deceased with respect, either by returning their bodies to their families or facilitating a dignified funeral when necessary

3. Promptly report the incident to an independent judicial or competent authority tasked with conducting impartial and effective investigations by fully cooperating and preserving all evidence.

4. If acts of torture, or other cruel, inhuman, or degrading treatment are suspected, immediate steps must be taken to prevent potentially implicated persons from influencing the investigation, and to restrict their contact with witnesses, victims, or the victim's family.

Investigations

The obligation to investigate every death in prisons, regardless of cause, is a key aspect of a state's human rights duties to protect detainees' right to life and the prohibition of torture and inhumane treatment. Such investigations are crucial for not only determining the cause of death, but providing justice to families, improving prison management, and preventing future preventable deaths.

Detention monitors, with their unique access to prisons and mandates, are vital in ensuring that investigations are carried out in the first place. They can also assess whether investigations into prison deaths meet international standards.

An effective investigation into prisoner deaths starts with transparent, thorough autopsies and independent oversight. Such investigations should ensure that each aspect – including potential liabilities and contributing factors – is reviewed. Recommendations for reform and improved prison management based on these findings can help prevent future incidents.

The UN Minnesota Protocol

The UN Minnesota Protocol on the Investigation of Potentially Unlawful Death provides guidance for thorough, impartial inquiries into potentially unlawful deaths. It specifies:

1. Human rights obligations require investigations of prison deaths to be independent, impartial, prompt and ex-officio, thorough, effective, credible and transparent.

2. The scope and methodology of an investigation into a death in prison should meet the objectives of determining the cause and circumstances of death, identifying underlying factors contributing to it, and, if applicable, establishing any individual or institutional responsibility.

3. Investigations should also identify any failure to take reasonable measures that could have potentially prevented the death, as well as uncover any systemic or policy-related failures that may have contributed to a death.

4. The **UN Nelson Mandela Rules** requires any prison death to be reported to an independent authority, evidence to be preserved, and prison authorities to cooperate fully in investigations.

PROMISING PRACTICE: Guidance on investigating prison deaths in Spain

In **Spain**, the Ministry of Justice's Guidance on Medical and Forensic Best Practice for Investigating Deaths in Custody provides detailed guidance for forensic medical professionals handling deaths in custody. It outlines a step-by-step approach to ensure uniform, thorough, and transparent investigations. There are general principles of action covered, including procedures for drafting expert reports.[7]

DETENTION MONITORS SHOULD:

- **Collect and review reliable sources such as investigations reports, death certificates, police reports, autopsy results, incident records, and testimonies from prisoners and staff, ensuring a thorough examination of deaths.**
- **Examine whether measures are in place to ensure accountability and transparency in cases where prison staff interventions, both directly (that is, involving the excessive use of force or the use of firearms in riots or escape attempts) and indirectly (for instance, when placing a new prisoner affiliated with one gang in a unit designated for a rival group) result in the death of one or more prisoners.**
- **Assess whether the investigations are conducted in full compliance with the Minnesota Protocol. For example, is the investigative body carrying out adequately detailed investigations, are they well-trained and equipped with resources needed, do they have a mandate to carry out impartial and rigorous inquiries?**
- **Engage with and assess the concerns of families and support networks vis-à-vis any investigation process, or lack thereof to make concrete recommendations to the relevant authorities and investigatory bodies**
- **Review the actions undertaken by relevant authorities to implement the recommendations issued by investigatory bodies. This includes evaluating whether these recommendations have been translated into tangible reforms, policies, or practices aimed at preventing future incidents.[8]**

7. Available at: www.mjusticia.gob.es/es/ElMinisterio/OrganismosMinisterio/Documents/Buenas%20pr%C3%A1cticas_Muerte%20en%20custodia%202023%20%28003%29.pdf
8. University of Nottingham, *Improving death investigations to promote safety, Case study: Prisoner deaths*, September 2023, safesoc.z6.web.core.windows.net/index.html@p=986.html.

PROMISING PRACTICE: The launch of a mandatory autopsy initiative for prison deaths in the Philippines

The prison system in the **Philippines** faces extreme overcrowding. Between 2015 and 2021, the number of people in prison surged by 75%, with 70% of prisoners held in pre-trial detention. These conditions have contributed to a prison mortality rate 2.5 times higher than the national average, exacerbated by poor and limited access to healthcare, coupled with a lack of death investigations to help reliably document and prevent custodial deaths, resulting in over 1,000 prisoner deaths annually. High-profile cases and potentially unlawful deaths, including victims of police killings from the so-called 'war on drugs', have further highlighted significant shortcomings in investigations, accountability and prevention.

Forensic investigation in the country has been hindered by structural gaps, including the absence of a national forensic institute, a central morgue, forensic legislation and a lack of certified forensic pathologists. The discovery of 176 unexamined bodies of prisoners at a funeral parlour in 2022, underscored systemic failures in forensic reliability and accountability.[9]

In response, the United Nations launched the UN Joint Programme on Human Rights in the Philippines in 2021, which aimed, among other objectives, to assist in the development of forensic capacity in the country. As part of this initiative, the Government sought technical assistance from the United Nations Special Rapporteur on extrajudicial, summary, or arbitrary executions. The programme encompassed the training of investigators and medical professionals in the application of the Minnesota Protocol for investigating potentially unlawful deaths, including those occurring in custody, and laid the groundwork for the establishment of a National Institute of Forensic Medicine, modelled on the elements and principles outlined in the Protocol. In December 2023, during the 75th Anniversary of the Universal Declaration of Human Rights in Geneva, Switzerland, the Government made a commitment to establish the National Forensic Institute. Subsequently, in January 2025, it issued a decree to initiate its implementation.[10]

In addition, the United Nations Office on Drugs and Crime (UNODC), along with the Department of Justice (DOJ) and the University of the Philippines, launched a mandatory autopsy initiative for all deaths in Metro Manila's New Bilibid Prison. A Technical Working Group was established in 2024 to standardise custodial death investigation procedures, improve data transparency, and enhance healthcare access for prisoners. This partnership aims to create the foundation for a future National Forensic Institute and to model investigative best practices that address structural issues within the prison system.[11]

With regard to forensics,
DETENTION MONITORS SHOULD:

- **Evaluate if and how forensic institutions exist and operates, including the adequacy of legislation to ensure standardised forensic procedures.**
- **Recommend standardised procedures for forensic investigations, such as uniform autopsy protocols, chain-of-custody for evidence, and transparent documentation protocols**
- **Assess the qualifications, training, and expertise of forensic professionals, particularly in their capacity to handle prison-related cases. Assess forensic processes and records by visiting mortuaries to review autopsy reports and findings, ensuring they are conducted according to professional and legal standards.**
- **Identify gaps in resources, infrastructure, or knowledge, and recommend specific improvements, such as enhanced training on prison-specific forensic cases or investment in modern forensic tools.**

9. See: chr.gov.ph/statement-of-the-commission-on-human-rights-expressing-concern-over-the-176-bodies-of-persons-deprived-of-liberty-unclaimed-in-a-funeral-home
10. Administrative Order 29 creating a technical working group tasked with the establishment of a National Forensics Institute (NFI).
11. See: doj.gov.ph/news_article.html?newsid=GfdTzCPoEhg6iuDK2-nFmA1UEccQxy3mMj4NFyLOVLI

Prevention

Data and findings of investigations should form the basis of evidence-based action to ensure a systematic and multi-faceted approach to address causes of preventable deaths in prisons. By referencing detailed protocols and best practices, countries like Chile[12] have made progress in preventing deaths in custody. Chile promotes a multi-agency approach to identify and address risks early through a legally binding protocol that mandates the Public Prosecution Service to investigate deaths to determine the circumstances, including whether they resulted from deliberate actions or negligence by those responsible for the individual's care. The protocol seeks to ensure prompt and thorough investigations, contributing to a unified national register of such incidents.

DETENTION MONITORS SHOULD:

- **Map key stakeholders both within and outside detention centres to ensure a comprehensive understanding of all relevant stakeholders responsible for the immediate response, the investigation and follow-up of any prison death.**
- **Assess and recommend improvement of collaboration frameworks among key authorities (which may include, healthcare services, police, etc.) at local and national levels to identify strengths, weaknesses, and gaps and recommend improvements to enhance communication, coordination, and overall effectiveness.**
- **Conduct thorough assessments of healthcare provisions within detention centres both locally and nationally to ensure that adequate measures are in place, thereby preventing preventable deaths in custody.**
- **Assess policy and practice around prisoner separation, especially in instances involving inter-prisoner violence, or where organised crime groups are prevalent to evaluate whether separation aligns with broader efforts towards non-violent conflict resolution and rehabilitation within prisons.**
- **Highlight contextual factors and structural deficiencies through data and findings to support actionable recommendations for systemic reform, such as alternatives to imprisonment, alongside improvements to prison infrastructure, architecture, regimes, and the transfer of responsibility for prison healthcare to national health authorities.**
- **Understand the circumstances of the deceased, including the nature of the sentences they were serving, or whether they were in pre-trial detention or other custodial conditions, to ensure that any patterns of disparity and disproportionality are adequately identified.**

12. The Intersectoral Protocol for Early Warning of Deaths under State Control, Custody or Care, 2019, www.camara.cl/verDoc.aspx?prmID=185862&prmTIPO=DOCUMENTOCOMISION

Discrimination in prisoner deaths

Deaths in custody often disproportionately affect marginalised groups, highlighting the need for proactive measures to mitigate potential discrimination. Policies and practices should explicitly account for discrimination based on gender identity, sexuality, race, ethnicity, disability, and mental health status. For instance, specific protocols should be enacted to separate vulnerable prisoners, including transgender and non-binary individuals, children, and those with mental health needs, from the general population in order to mitigate any potential risk of harm. However, it should be acknowledged that other groups, such as older persons, persons with disabilities, and those at risk of suicide, may also be particularly vulnerable to different forms of harm, including death.[13]

Additionally, adequate classification of prisoners based on the type and severity of their charges, such as separating those in pre-trial detention from those who have been sentenced, can reduce instances of violence and exploitation. Prevention efforts should also address ethnic tensions, gang violence, and inter-prisoner violence, which are exacerbated by overcrowding and inadequate staff training. Finally, providing diverse, inclusive work and educational programmes within prisons further minimises inter-prisoner violence by fostering a safer environment.

Detention monitors play a key role in advocating for the incorporation of disaggregated data analysis in their reporting, ensuring that disparities are explicitly highlighted and contextualised, and providing evidence-based, granular insights to reduce preventable prison deaths.[14]

DETENTION MONITORS SHOULD:

- **Adopt an intersectional perspective to better understand how overlapping identities, particularly those with specific health needs, such as older prisoners and those with medical conditions, may increase vulnerability**
- **Analyse available data, especially if disaggregated, to identify any groups disproportionately affected by discrimination and violence adversely impacting their health or other. Where data is not disaggregated, advocate for the collection and reporting of such data to better understand trends and ensure accountability.**
- **Evaluate instances of state-perpetrated violence that has led to death by investigating signs of direct involvement, corruption, or abuse of power by authorities.**
- **Assess the quality and availability of healthcare services and any barriers experienced by certain groups in prison**

13. International human rights standards, such as the UN Nelson Mandela Rules, the UN Bangkok Rules, and the Yogyakarta Principles, provide a comprehensive framework for preventing deaths in prison by advocating for prison management approaches rooted in human rights principles.

14. Tomczak, P., & Mulgrew, R. (2023). Making prisoner deaths visible: Towards a new epistemological approach. Incarceration, 4, 26326663231160344.

Methodological considerations for monitoring prison deaths

Detention monitors should consider the following points in preparing, undertaking and following-up on prison deaths:

01 **Design a context-specific monitoring instrument on prison deaths** (See example from Brazil below).

Such an instrument or tool, drawing on this Guidance Note, would enable systemic monitoring of the complex issues at play. It should include sources, considerations and factors that are both regional/ country/ facility-specific, data that is available, etc.

02 **Ensure that investigations into deaths in custody, regardless of the apparent cause, comply with international standards**, particularly the Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016). This protocol is crucial as it provides detailed guidelines for conducting impartial, transparent and thorough investigations into deaths, ensuring that human rights are upheld.

03 **Secure full access to all relevant data**, documents, and premises required for a thorough investigation.

Monitors should work to ensure that state bodies uphold their responsibilities to preserve and provide all pertinent materials, enabling a comprehensive review and safeguarding evidence integrity.

04 **Consider undertaking** thematic monitoring visits, potentially across multiple facilities, to gain a thorough and comparative analysis.

This approach will facilitate a more nuanced understanding of the underlying causes and trends on prison deaths.

05 **Set up multidisciplinary monitoring teams** with expertise across forensic analysis, healthcare and human rights to enhance the depth and scope of detention monitoring regarding findings of prisoner deaths and recommendations on reducing preventable prisoner deaths.

06 **Identify issues with respect to safety concerns**, particularly in cases involving individuals with affiliations to organised crime, as well as the broader, interconnected issues such as drug use and the influence of criminal subcultures.

Detention monitors should seek to understand the underlying dynamics of these subcultures, which may differ from one facility to another.

07 **Ensure the meaningful participation of prisoners' families and support networks, including of foreign nationals, in detention monitoring**.

Acknowledging the critical role they play in providing context and relevant information, monitors should engage with the bereaved loved ones.

08 **Assess how persons belonging to vulnerable and/or marginalised groups are impacted**, such as those at higher risk of physical and psychological violence, racialised groups, foreign nationals, women, children, members of the LGBTQI+ community, persons living with disabilities, and others.

PROMISING PRACTICE: Brazil's National Preventative Mechanism monitoring methodology for the 2017 'prison massacres'[15]

The Brazilian National Preventive Mechanism's (NPM) monitoring approach to the 2017 prison massacres provides a practical framework for investigating deaths in custody globally, especially in complex situations involving overcrowding, violence, and organised crime.[16] In response to the events that led to over 126 deaths across several prisons, the NPM devised a multifaceted methodology to assess the deaths and system-wide failures contributing to the tragedies. This approach, especially its use of prior recommendations and comprehensive documentation, serves as a guide for preventive mechanisms worldwide.

To understand and address the underlying issues, the NPM's methodology included a **thematic monitoring instrument** designed to categorise findings visually and systematically, grouping related themes for enhanced clarity. The inclusion of historical recommendations within this tool enabled the NPM to identify patterns and gaps, such as prison overcrowding, racial and ethnic disparities, and the challenges associated with precarious penitentiary administration, informing a more insightful analysis of detention conditions and systemic deficiencies. In addition to reviewing official records, the NPM relied on varied information sources, such as prison administration data, public attorney reports, and news outlets to triangulate and verify the data obtained. This multipronged information-gathering approach is crucial for NPMs seeking to prioritise and select sites for visits, particularly in scenarios where reliable information may be limited or inconsistent.

Key monitoring considerations for NPMs include understanding contextual factors such as overcrowding, ethnic disparities, and staffing inadequacies, all of which amplify risks in detention environments. Findings from the Brazilian case reveal that excessive use of force, inadequate recording protocols, and inconsistent data on deaths exacerbated prison violence, further complicated by state attribution of violence solely to conflicts between gangs without scrutinising potential oversight or neglect. The NPM's assessment process emphasised the need for an independent, clear and accountable action plan from authorities, with specified timelines and responsibilities to address identified gaps in prison management.

15. PRI (2024). Deaths in prison – an online workshop for detention monitors: Case study. 17 October 2024.
16. The report of the Brazilian NPM is available here: https://mnpctbrasil.files.wordpress.com/2019/09/relatriodemonitoramentoderecomendaes.pdf.

About Penal Reform International

Penal Reform International (PRI) is an independent non-governmental organisation that develops and promotes fair, effective and proportionate responses to criminal justice problems worldwide. We work to promote criminal justice systems that uphold human rights for all and do no harm. We run practical human rights programmes and support reforms that make criminal justice fair and effective. Our primary objectives are to secure trials that are impartial, sentencing practices that are proportionate and promote social rehabilitation, and humane conditions of detention where alternatives to imprisonment are not possible. We work through country missions, regional hubs, remote coordination, and through partners.

www.penalreform.org

About *prison*DEATH

Preventable prison deaths are common in every country, causing significant harms to families, prisons and societies. *prison*DEATH (2022-2024) brought together a multidisciplinary team from the University of Nottingham (Prof. Philippa Tomczak), University of Galway (Dr. Róisín Mulgrew), St Olavs University Hospital and the Norwegian University of Science and Technology (Dr. Catherine Appleton). Facilitated by the University of Nottingham Faculty of Social Sciences, this academic team worked in partnership with Penal Reform International and the international community, seeking to put the overlooked issue of prison deaths on the global penal reform agenda.

www.nottingham.ac.uk/research/groups/prisons-health-and-societies/research-projects

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