

Joint Committee on Human Rights

Uncorrected oral evidence: [Mental Health and Deaths in Prison](#), HC 893

Wednesday 15 March 2017

3.15 pm

Written evidence from witnesses:

- Deborah Coles, Chair, Director, [INQUEST](#)
- Andrea Albutt, President, [Prison Governors Association](#)

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Members present: Ms Harriet Harman; Ms Karen Buck; Baroness Hamwee; Baroness Lawrence of Clarendon; Jeremy Lefroy; Baroness O’Cathain; Baroness Prosser; Amanda Solloway; Lord Woolf.

Questions 76 - 94

Witnesses

I: Deborah Coles, Director, INQUEST; Dr Andrew Forrester, Consultant and Honorary Senior Lecturer in Forensic Psychiatry, South London and Maudsley NHS Foundation Trust and Institute of Psychiatry; Rt Hon Lord Bradley PC.

II: Mike Rolfe, National Chair, the Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers (the POA); Andrea Albutt, President, Prison Governors Association; Mike Trace, Chief Executive, Rehabilitation for Addicted Prisoners Trust (RAPt); Mark Johnson, Founder, User Voice.

Examination of witnesses

Deborah Coles, Dr Forrester and Lord Bradley.

Q76 Chair: Thank you for coming. As you know, we are the Joint Committee on Human Rights, which means that we are half House of Commons and half House of Lords. We are looking into the very important issue of people with mental health problems committing suicide in our prisons. Harry, you have a disclosure to make at the outset, have you not?

Lord Woolf: I disclose my interest as president of the Prison Reform Trust and previously a fellow trustee of one of the witnesses. I also have a role in various other bodies interested in penal affairs.

Chair: Thank you very much for coming to help us with our inquiry. Perhaps I could ask each of you to speak in relation to my first question. There has been a rise in self-inflicted deaths. Do we not know why this is happening and what to do about it? Should we be having a different sort of inquiry about why this is happening, or do we know what is happening and why it is on the increase but things that have been recommended in the past have not been implemented? If so, what key things do you think would make a difference if they were implemented? The Prisons and Courts Bill will be making its way through the Commons and Lords, so this is an important moment for us to focus on what could be done.

Lord Bradley: Thank you for inviting me to give evidence. I should declare that I am a trustee of the Prison Reform Trust and the Centre for Mental Health, and I am on the Government's Advisory Board on Female Offenders. I say that so that you are aware of those connections.

In my view, the underlying problem is that too many vulnerable people with mental health, learning disabilities and complex needs are inappropriately sent to prison. We have a huge number of vulnerable people in a prison population of 85,000. In recent years, the number of prison officers who can help and support vulnerable people, and therefore the capacity in prisons to deal with those numbers, has declined. In many ways, if you are in that situation, the prison officer on the wing is your principal carer. If there is inadequate staffing in a prison, that undermines the opportunity to support and help vulnerable people.

There is a problem with the overcrowding environment in which vulnerable people are placed, which means that they do not have the opportunity for proper, meaningful support and activity within the prison, and there is inadequate healthcare within prison to meet the demands of the huge number who have a range of complex needs and a spectrum of mental health problems.

I strongly believe that to change that you have to change the flow of people upstream, where appropriate, away from a custodial sentence by better use of community sentences, better understanding of the health needs of individuals earlier in the system and the development of liaison and diversion services, but for that to be really effective you have to have a proper investment in community services to ensure that those services are there. Quite often, people offend because those services are not available in the community in the first place. If you are to administer community sentences effectively, those services have to be available, and over time you can have much more information and knowledge about individuals. You know those who need to have custodial sentences. When those people arrive in that situation, you have more information and knowledge about them and you can shape services in prison by reducing the numbers more effectively.

Deborah Coles: I fully concur with what Keith said. In answer to your question, I want to start with accountability and learning. My biggest frustration and sadness, coming from an organisation that has a long history of working with bereaved people, is that there is an overwhelming body of evidence about what has gone wrong, in fairness probably over the last 20-plus years. That emerges from investigations into deaths, inquests, coroners' reports, inspectorate and monitoring board reports and evidence from reviews.

I was involved in Baroness Corston's review of women in the criminal justice system and Lord Harris's review. Time and time again you see recommendations alerting the state to problems, in particular problems about safeguarding the lives of vulnerable people in prison, and the failure of existing systems and procedures. The problem is that there is no overarching framework by which those recommendations are audited, monitored and followed up. Therefore, you tend to see ad hoc initiatives, or you might get some changes in an individual prison but it is not sustained across the prison estate. For me, that is probably one of the real issues.

We need to have a far more effective system of analysing and responding to recommendations that are made. Ultimately, those recommendations, particularly when we are looking at individual deaths, come out of investigations, inquests, jury findings and coroners' reports that are designed to try to safeguard lives in the future. When you look at the obligations under Article 2, the learning of lessons and rectifying of dangerous practices is at the heart of those.

You took evidence last week from two families. The difficulty that INQUEST finds is that you tend to have a response to a critical inquest finding that is very much prison-limited; in other words, a lot of the learning that could be disseminated around the prison estate does not happen because there is no framework.

Alongside our work, increasingly we are aware that people are being imprisoned who simply should not be there. Following up Keith's point, the problem is that prison is seen as the default to failings in lots of other systems, not least mental health services. It is frustrating, because there are initiatives. It is very positive that we now have diversion schemes, but the problem is that there is no national provision and it is dependent on the sustainability of funding. Likewise, a lot of the families we work with will talk about the difficulties they have had accessing mental health services or services for learning disability and drug and alcohol problems prior to their relative being imprisoned. You see repeated examples of people who are put into a system that is ill equipped and ill resourced to deal with the complexity of vulnerable people's needs.

Q77 **Chair:** How is that put right?

Deborah Coles: I would say a drastic reduction in the use of prison. Prison is expensive and ineffective and does not work. We need look only at reconviction rates. If we diverted people into a lot of the very good

community-based projects and properly resourced them, we might well have a much more effective way of dealing with the very problems that led people into the prison system in the first place.

Dr Forrester: Thank you for asking me to give evidence. We have known for quite some time what works in the delivery of mental health services in prisons, and in some regards we are doing it but in many places we are not.

There are five key components. One is screening at prison reception, ideally with a mental health component. The second is triage: that is, doing a second assessment within the 72 hours after a person comes into prison. That is effective because reception can be very busy. People coming through reception at prison are often missed when they are screened for the first time. The third is providing comprehensive assessments across the board for people who have specialist needs. That is about 15% of the prison population. I mean specialist psychiatric and psychological assessments. The fourth is providing interventions for those who require them. Those interventions can be across a range of difficulties, from primary care level mental health problems, such as depression and anxiety, right up to people with very acute mental health problems who require urgent diversion from prison into hospital settings. The people with acute needs at the top end form about 2% of those in remand populations.

The final thing that we should be doing, arising from international evidence, is providing a system of reintegration. That means providing essentially through-the-gate services but with a clinical component attached to them. We know from the evidence that that is effective in helping people engage subsequently with services in the community. We are not doing that across the board as yet.

I want to make a few other points. One is about underprovision in clinical services, in particular psychiatry and psychology. Some prisons have no clinical psychology, or perhaps they have a day of clinical psychology. It is grossly inadequate for meeting the needs of this sort of population.

The second point is about diversion. It is clear that liaison and diversion services have developed considerably. At the moment there is, I think, about 50% coverage, and hopefully it will continue to develop. They can make a difference. However, when it comes to diverting people from prison into hospital care there are serious problems. There are some reports of people waiting for 100 days or more before they are diverted into hospital where they can be treated. That is a problem because people cannot be treated under compulsion in prisons; the Mental Health Act does not apply, and of course there would be problems if it did apply in prisons.

The final point I want to make is about the deteriorating prison environment. That in its entirety has a profound effect upon the well-being not only of the establishment but of the individuals who are located within it. These are things like time out of cell, time available to attend

education, time to go to the gym and available time to attend medical, clinical appointments.

- Q78 **Lord Woolf:** The problems are very great and will not be overcome overnight. Are there any things that you think could be done in the short term as well as the transformation of the situation, which I think between you you have described as being urgently needed and could be done and help? In that connection, I wonder whether key workers should be available: that is, people who are identified and perhaps given a limited amount of special training to give support to vulnerable people who suffer mental health problems. What would you say about that?

Lord Bradley: It is part of the jigsaw, but earlier intervention prevention measures upstream are equally important. Andrew mentioned having assessment at reception in prison. Information should have been collected from that person at worst at the first point of contact with the criminal justice system: that is, at the police station where liaison and diversion teams will help with that assessment. That information should then be shared with the court for the first appearance.

The advantage of it is that you can reduce the number of people on remand waiting for that information to be collected for the court. That is particularly important for women. Often, these are low-level offences. The consequences of women on remand are potential family breakdown and children taken into care, and it would be a far better use of community-based women's provision for remand or bail. If they need to go from the courts to prison, that continuity of care and information sharing along the criminal justice pathway is crucial. Therefore, the people who can support people when they arrive in prison have a lot more knowledge about them when they arrive, so the reception is then enhancing that information, not collecting it for the first time, or, as often happens, collecting it for the sixth time but there has been no sharing of the information among the agencies dealing with the person.

Then you can put round it a package of care, of which that mentoring support and key work activity links to the pathway, but crucially there is a link when people come out of prison and go back into the community so that information and connection of support continues, with the objective of trying to stop reoffending behaviour. It is an element, but I think upstream work could have a bigger impact, because you could try to reduce the number of people who need that support, but then you could tailor it in prison much more effectively.

To pick up Andrew's point about transfer from prison to mental health services, this is absolutely crucial. In my report back in 2009 I recommended 14 days. That was meant to be a lever for change. I am afraid we have gone backwards: first, because of the time it takes to get assessment in the prison setting, and, secondly, the availability of beds in secure mental health provision to transfer people to, so we need to tackle both of those as well.

Deborah Coles: What you have said is interesting, because we used to have personal officer schemes. When I was involved in Lord Harris's review, it was an issue that we looked at and talked to staff about. Looking at the current situation within prisons, if you ask prison officers what opportunity they have to develop meaningful relationships with people in prison, they would probably say it is limited because of the pressure on staffing and resources. If you had a smaller prison population, you could have a much more therapeutic environment and staff who were specially trained. Training is an important issue here. Staff training in working with vulnerable people is extremely limited; it is no longer mandatory to have suicide awareness training or mental health training, other than when it is covered in the initial training period. I think staff are often left in a difficult position.

Keith referred to women in prison. Before I came here, I looked at the deaths of women last year. Last year, 22 women died in prison. That is the highest number on record. Of those, 12 took their own lives, and the majority of those who died were serving sentences for non-violent offences and had histories of mental ill health. The offences related very much to mental health and drug and alcohol problems. Obviously, the inquests and investigations have not yet been concluded in those cases, but this is no different from what Baroness Corston reported on 10 years ago; it is the same demography of women we are still imprisoning.

To go back to my answer to the first question about personal officers, Lord Harris made a recommendation about having rehabilitation officers. That recommendation was rejected, albeit I think the Government are considering something. We used to have this, but because of pressure it has not been possible properly to implement the personal officer scheme. However, relationships between staff and prisoners are absolutely fundamental; it is what keeps prisons functioning.

Dr Forrester: To an extent, we already have key workers, because people who have mental health problems and are under the care of mental health services in prisons are within the care programme approach. People with severe and enduring mental health problems would have care co-ordinators allocated to them. However, there is a whole lot of other people who do not have severe and enduring mental health problems and do not have within healthcare care co-ordinators allocated to them. That might be a useful way forward.

In my experience, it works most effectively when these same co-ordinators do not work just in prisons but in other parts of the criminal justice pathway, meaning that, for example, sometimes they also work in the local magistrates' courts, and perhaps they also have some input into police custody. That is effective precisely because, referring to Lord Bradley's point, it helps to divert people away from the criminal justice system, particularly those with acute mental health problems before they arrive there in the first place.

Q79 **Lord Woolf:** I seem to remember there were quite a number of initiatives about having mental health skills available in magistrates' courts. How

extensive is that now?

Lord Bradley: The development of those teams is now principally in police custody, but they flow into the courts as well. It covers 53% of the country. We had additional money allocated last July to enable the rollout to get to 75% of the country by 2018-19. There is continuous evaluation of the effectiveness of the schemes with a view to the provision of the last tranche of money to enable 100% coverage by 2021. That enables psychiatric nurses working alongside police custody officers, charging sergeants, the CPS and defence solicitors to have that information immediately to hand in determining what the next step should be. They may have committed a low-level offence, or even a more serious one, because they have just become disconnected from the services. That information is available in police custody with the psychiatric NHS documents for that individual. Alongside that, the police have their records.

It works even better further upstream where they are out doing street triage identifying people in crisis. Where it is appropriate, they are diverted to places of safety in the community for that assessment to be undertaken, not even at that point, with agreed protocols with the police, taken to police custody, because police cells are not the most appropriate place for that assessment to be undertaken.

Schemes have developed really well where they have extended the remit of places of safety into what are called crisis assessment units, sitting alongside the same staff in Section 136 places of safety. That is where people have been sectioned under the Mental Health Act, but equally people in crisis need that support and help at that moment to be assessed. With agreed protocols between the NHS and the police, they make that assessment, and the individual may then need to go to the police station because they are to be charged. That information may need to be at the court at the first appearance, but a much more continuous service has been developed to support the vulnerable person at that point.

Lord Woolf: Is progress being made, as was hoped at one time?

Lord Bradley: A recent report estimated that up to last year about 50,000 people had been diverted away from the criminal justice system because of intervention at the earliest point of contact.

Deborah Coles: Sadly, we also deal with deaths in police custody or following contact with police officers. The problem is provision; there simply is not enough. Sadly, I see too many examples of people ending up going into police custody because of lack of alternative places of safety. The Committee might want to consider, in terms of human rights, whether or not we can honestly say that police stations and prisons can be places of safety for people with mental ill health. The reality of our prison system is that anybody with mental health issues will become a lot more ill by being in prison because of the nature of prison at the moment. Even for those who enter prison without mental health issues,

when we look at people being locked up in cells for long periods of time, we need to talk to people about how that impacts on mental health. We have places of safety at the moment that exacerbate people's mental ill health.

Q80 Ms Buck: Andrew, referring to your five-point strategy for early intervention, what would it take to implement that? Is that something you have mapped out and costed?

Dr Forrester: I have not costed it. It arises from the international evidence as to what works in clinical mental health pathways. If we look at the different points in the five parts to it, we are at different stages with each of them. For example, with reception screening we have gone quite far. Reception screening is now a standardised part of the journey for everyone coming into prison.

At the other end, with reintegration, we are at the beginning in regard to healthcare services. Some through-the-gate services are provided, but relatively few clinical providers offer such services. In the middle, there is huge variation across the country in the number and quality of services provided and the range of available interventions. For example, some places provide IAPT—improving access to psychological therapies—services, such as psychotherapy for common mental disorders such as depression and anxiety, and other areas have no services like that at all. I think it would be possible to look nationally at all the different aspects of this model and work out where we are, but that is not being done.

Ms Buck: We all accept that resources are part of this; the size of the prison population and staffing reductions will be part of the problem. Are there cultural, structural and procedural barriers particularly to the information sharing and the cascading down of that kind of approach into prisons that go beyond just saying that if we put in an extra couple of hundred million pounds it would transform the system, and what would that be?

Lord Bradley: Clearly, information sharing relies on consistency of the technology that underpins it. The Prison Service is about to roll out a new national computer system. Having been the Minister in DSS who looked at the Child Support Agency all those years ago, I am always slightly cautious ever to claim any expertise in this area, but the idea is to be able to link prison health records to community-based health records. I think Andrew would agree that a major step forward in the provision of healthcare in prison came with it being commissioned through the NHS. The commissioning arrangements are not ideal, but at least if it is commissioned through the NHS the linkages back into the community through NHS patient records, whether mental health records or primary care records, makes information sharing much easier. I go out on street triage and see a psychiatric nurse and a police officer. They still sit side by side each with their own laptops, but at least they are in the same place talking to one another and sharing information. It is not ideal, but the idea is to link it all up.

We may come on to this, but perhaps I may add a comment about better use of community sentencing.

Ms Buck: We will probably come on to that, so do not go into it too much, if you do not mind. I want to ask a couple of questions about some of the previous evidence we heard about the assessment, care and custody process. You may not have any particular knowledge of this, but is there a particular issue with personality disorders? Is that an additional complication in the system? If so, what would it be?

Dr Forrester: The evidence for the prevalence of personality disorder puts it somewhere in the region of 70% among prisoners. We also know that there are many diagnostic comorbidities. Many prisoners have more than one mental disorder. The services that have been provided for personality disorder so far have developed considerably over the last decade or so with the advent of psychologically informed prison environments and so on. There is some evidence that these are helpful where they exist. They are helpful mainly at the moment for sentenced prisoners—people who are serving their sentence and go into these essentially more therapeutic environments for treatment of personality disorder—but within the remand population and flow of the population into prisons, services for personality disorder are not really provided in the same way. There is instead a focus on major mental illness: that is, severe and enduring mental illness and so on.

Lord Bradley: Personality disorder is a very complicated area. What we do not have well enough in prisons is an equivalence of healthcare that you would get outside prison. The spectrum of primary, community, secondary and specialist care tends not to happen in the same way—it is not ideal in the community—in prison. Therefore, for prisoners the thresholds to get into healthcare tend to be too high, and you do not get the low-level primary care end effectively enough to stop the escalation of the problem while people are in prison.

Q81 **Ms Buck:** That is very helpful. We have been talking about information sharing in general. I do not know whether you were aware of the evidence we heard particularly from the family of Dean Saunders and others last week about the role of the family or other carers and supporters. The mother of Dean Saunders gave us some very painful evidence about pleading with the prison authorities about the risks to her son and yet the family was not involved in the review process at all. What is your view about why that would happen? Is that a structural or cultural problem, and what would be the best recommendations to make to ensure that where appropriate—it may not always be appropriate—families and others are involved in that process?

Deborah Coles: I was here with the family. I think it is a structural and cultural problem. Sadly, it is a problem we see all too often in our casework. The reality is that the ACCT process makes it very clear that families should be involved, where appropriate, particularly in supporting at-risk prisoners. Bear in mind that many of the families we are talking about have done a lot of work caring for and supporting their relatives in

the community. Often, they know most about them and could be of real assistance to the staff who are charged with their care. I am sure it is a combination of overwork and pressure. The fact is that now pretty much every inquest finding makes a comment on lack of information, exchange communication and a failure of the ACCT process. Therefore, it is a well-known problem.

There is perhaps also an issue about the time involved in contacting families, maybe getting them to come along to the prison and be involved in the ACCT process, and a cultural resistance to families getting involved at that stage.

Ms Buck: That is what we are trying to unpack. In terms of making specific recommendations, how much of it is a resource problem?

Deborah Coles: It is not just a resource problem because it is something we have seen for many years before the attention paid to shortage of staff. I think it is a cultural problem. If you are doing proper, holistic care of vulnerable people, you should involve those who best know the individual, and that will very often be the family, as well as contact community services, if indeed they have been involved, because the more information you have, the better you are able to protect that person's vulnerability.

Dr Forrester: When people are under a care programme approach, there is meant to be liaison with family as a core part of care planning, so in some ways the mechanism already exists for that to take place. However, I would agree with the point that it is largely a cultural issue and over many years it has been difficult to move that forward.

Not every person in prison consents to having contact made with the family, and that is something worth bearing in mind. None the less, in the rush of the other work it is often something that is forgotten about.

Ms Buck: Having an explicit protocol that requires you at least to check, and in some cases there will not be permission, does not exist at the moment.

Dr Forrester: It does exist under the care programme approach framework.

Ms Buck: Yet the cultural resistance can sometimes override it.

Dr Forrester: Yes. Probably what happens is that in the rush of other work it is forgotten about, and in some places there is probably cultural resistance to it.

Ms Buck: In the case of Dean Saunders, and I am sure others, there was an issue about them being desperate to speak to their families and they found it difficult to get access to them on the phone. In some cases, that has to be balanced against the fact that it may not always be right for the families or for others to have that phone access, but what is the best protocol to ensure that vulnerable and at-risk prisoners have the right

access to their families?

Deborah Coles: I know good practice exists. Sadly, I am always talking about the consequences of our work, which is death, but I know that in the course of talking to families there is an individual officer who will have facilitated a phone call. That is not difficult, but it goes back to Lord Woolf's earlier question about recognising that that is what somebody needs and having the trust so they can say, "Dean, you probably would benefit from a conversation. I'll take you into the office and you can make a quick call". There is also an issue, which I am sure others can speak to, about access to a phone when somebody first goes into prison.

Ms Buck: It should not be down to good will and discretion, should it? That is the point.

Deborah Coles: No. You should have a phone call immediately. Staff should also be aware if somebody is not making contact, because that can often be a trigger.

Baroness Prosser: Is this in part due to lack of experience and training of staff? If you have quite new staff who are not embedded in the positive sides of the culture, I imagine it is probably quite difficult for them to think on their feet.

Lord Bradley: It is my understanding—it may be wrong—that under prison policy you are required to facilitate a call within 24 hours of arrival in prison. I think the demands, culture and training are all part of ensuring that happens. It is not just about training prison staff in mental health issues; it is about training across organisations, because they are all dealing with the same person. Breaking down some of the cultural and organisational barriers comes about by training them together around the needs of the individual. That has a dramatic impact.

When we were unfolding liaison and diversion I went to a training session with psychiatric nurses and police officers. The first time I went, on one side of the room were all the nurses in their very smart uniforms, on the other side of the room were the police officers, all looking very smart in their uniforms, and there was a gap down the middle of the room. Two years later when I went back I did not know who the police officers were and who the nurses were, because they now work together and break down cultural and organisational barriers. I think we need to do the same with the Prison Service.

Q82 **Lord Woolf:** Mobile phones are now regarded as a menace in prisons. Surely they can be available in a way that means that they can be used only for positive purposes. In that regard, would you be in favour of the availability of mobile phones to people who need to be in close contact with their families?

Dr Forrester: I will make a slightly related point about in-cell booking systems at some prisons. At Thameside prison in south London, I am aware that computer systems are installed in some cells to enable prisoners to make bookings with healthcare and so on and arrange

movements. By all accounts, that seems to work reasonably well. The idea is to roll that out into other prisons. So the introduction of technology into prisoner life can be useful.

As to mobile phones, I am not sure there has been much research about their use inside prison settings, but in theory at least they could enable some sort of access to healthcare, families and so on. Of course, I am sure the Prison Service would have a view about security issues.

- Q83 **Baroness Hamwee:** My question is mainly for Deborah, but others may want to come in. You have already used the phrase “lessons learned”. Clare Hobday Saunders was very forceful about that in a previous week, and everyone says that lessons are learned but they are not. I understand that the new Prisons and Courts Bill, which I suppose is part of putting the ombudsman on a statutory basis, will require the Secretary of State to respond to reports from the ombudsman. Do you think we should be looking at a similar power for coroners to make recommendations and for there to be an obligation, perhaps on the Secretary of State, maybe more widely, to respond to those reports?

Deborah Coles: It goes without saying—I mentioned it earlier and covered it in our submission—that that is one of our biggest frustrations. At the moment we have the PPO making recommendations that are not subsequently followed up. It does not have the resources to follow that up. The only time its recommendations may be reviewed is when there is another death or the prison inspectorate goes into the prison and checks against the action plan and recommendations. You have a kind of lacuna where in the intervening period, which could be many years, there is no response.

As to coroners’ reports, we did a lot of work—indeed, Harriet was involved in it—around the Coroners and Justice Act. One intention behind it was to recognise the preventive potential of coroners’ inquests. We now have a situation where coroners’ reports are on the judiciary website and there is an obligation on the part of whoever they are directed to, such as the Prison Service or NOMS, to respond within 56 days. The problem is that nobody is following up and checking what has happened in response. I have seen too many cut-and-paste responses to coroners’ reports, particularly on prison deaths. Nobody is charged with following it through. I think there would be more accountability to Parliament, perhaps to Select Committees, in having an audit of all the recommendations that have been made in relation to prison deaths, for example, and somebody who is monitoring and following up what has happened.

Baroness Hamwee: Who should that somebody be?

Deborah Coles: INQUEST gave evidence to this very Committee back in 2004. I reviewed our evidence and the Committee’s response, and we argued at the time that we thought there should be a standing commission on custodial deaths. There definitely needs to be an independent oversight mechanism whereby for any death that engages Article 2, where there have been recommendations and coroners’ reports

made, there should be an obligation to respond, but that needs to be independent of the government organisation.

We also want to try to ensure cross-sector learning. So many of the issues on which coroners will make reports will have relevance not just to prison deaths but possibly deaths involving the police or mental health settings. We have had various initiatives as a result of work that has been done over the years. We have a ministerial board on deaths in custody and we have learning lessons bulletins coming out from the PPO, but the reality is that that has not been able to address the fact that time and time again we see the same lessons not being learned.

Baroness Hamwee: I am trying to pull together those two separate thoughts. It would be an independent person with a responsibility for some sort of system, but it would have to be the Secretary of State, would it not, who was required to take action?

Deborah Coles: Yes.

Chair: If you are talking about some independent person or body to follow up and audit what has and has not been actioned from the ombudsman, inspectorate and coroner, sometimes it is easier to get a new body set up because it allows a Minister to feel they have taken an initiative in that way, but sometimes it is easier to give the responsibility to an existing body because you do not have to set up a completely new structure. If you were looking at an existing body, which has the most analogous skills for it to be given that responsibility?

We do not want to go on like this, do we? You have all done expert work and, as we have heard in evidence given to us from previous witnesses, there is a level of impatience, especially when the end result of not learning these lessons or implementing findings is death. We do not want to go on like this, so we are looking for very practical measures. Who would it be? Could it be the Equality and Human Rights Commission? I am just throwing out thoughts.

Deborah Coles: It is a difficult one to answer because I cannot think of any body that could do that role.

Chair: Not the prisons inspectorate.

Deborah Coles: I am saying that the issues cross over.

Chair: We understand the problems. What is the solution, because we want to move on to practical proposals?

Deborah Coles: It needs to be a national oversight mechanism. Something new needs to be set up, because what we have at the moment has not worked. The Ministerial Council on Deaths in Custody was an attempt to deal with some of the concerns that have been raised.

Chair: But, as you say, that is not independent.

Deborah Coles: It is a talking shop. The National Preventive Mechanism, from whom you might be hearing evidence, is a possible route.

Chair: What about the Equality and Human Rights Commission, if the right to life is lost and it is following that up very specifically?

Deborah Coles: If it was given the proper resources, a proper brief and was reporting to a parliamentary Committee, with responsibility from the relevant Ministers and Secretaries of State, that may be an option.

Q84 **Baroness Lawrence of Clarendon:** Human rights standards have laid down a positive obligation for prison authorities to protect the right of life in custody. What should this mean in practice for prisoners with mental health conditions?

Dr Forrester: I think it means providing adequate services across the range of the model that I described earlier, because we know from the international evidence that that model, or aspects of it, works. I think it is about ensuring we provide adequate services, particularly for those coming into prison and prison reception, screening and so on, and that we have a wide range of assessments available for people when they come into prison.

There is also something about the prison environment and thinking about the requirements of the Nelson Mandela rules—the minimum standards for the treatment of prisoners. In particular, rule 43 talks about time spent in cells and in segregation. The minimum standard required is of the order of 22 hours in a cell with two hours out of cell per day. I think there is evidence that we are not meeting those minimum standards in parts of England and Wales, which is a problem.

Chair: Is it laid down in the prison rules?

Dr Forrester: They are in the Nelson Mandela rules. They say that prisoners should have a certain number of hours outside their cell per day, and in some instances those rules are being breached in England and Wales.

Chair: Are these statutory instruments—secondary legislation?

Dr Forrester: It is an international legislative document.

Chair: I am talking about our legislation. We have prison rules, have we not? What is the situation about maximum time in a cell in our prison rules?

Dr Forrester: We know that people are spending inadequate times out of their cells from recent work from, I think, HM Inspectorate of Prisons, and that people should be spending essentially more time out of their cells than they are.

Baroness Prosser: But there are no definite numbers laid down in the rules that say every prisoner must have at least X number of hours.

Dr Forrester: I cannot tell you those definite numbers. I do not know whether anyone else knows if they are laid down.

Lord Bradley: It seems to rely on operational needs at any particular time. I am not saying there are no rules, but securing the safety of the individual often means they are locked up, but the consequences for vulnerable people are much more dramatic than they are for non-vulnerable people in prison, if I can put it like that. It is not an ideal definition. If you have mental health problems, there are consequences in not having that ability for physical activity, not having meaningful activities and not having access to high-quality care. Even if you are in segregation under the Nelson Mandela 46 rule, you have a right to decent healthcare, and I fear that because of pressures within the prison system on numbers and staffing we are failing quite badly on each of these elements.

Q85 **Baroness O'Cathain:** I apologise for being late. If the idea of having 22 hours in cells and two hours out is not followed and prisoners do not get the hours outside their cells that they are supposed to get, can you walk us through what happens to the prison authorities? Does anybody know about this? Is there a reporting of this to anybody? Who takes responsibility for it? Can these prisoners be stuck there week after week on that sort of basis and no sanction or action taken?

Dr Forrester: I am not able to speak on behalf of the Prison Service, but I can speak about the mental health effects of being held in custody for longer periods of time than should be the case. We know broadly from the international literature that it can have a detrimental effect on mental health.

Chair: Detta, perhaps you can ask our next witnesses that very important question, because that is very pertinent.

Baroness O'Cathain: It seems to me there are so many bodies and people with a whole lot of information not talking to one another. It is not going up or down the chain, or to the left or right of it. Anyway, I will wait.

Lord Bradley: I believe that the Prisons and Courts Bill, where responsibility for ensuring standards within prisons reverts clearly to the Secretary of State, would be an opportunity to pursue some of the issues you have rightly identified.

Baroness Lawrence of Clarendon: Before we move on, it is something like a statute, where the Government say how long a prisoner should stay in his cell and how long he should be allowed out, which is a bit like the point the Baroness has put to you. Nobody is held to account. The Government have laid down how long they believe a prisoner should be in his cell and how long he should be outside it. Who makes those challenges? Who holds the Government to account? There should be somebody within the service who keeps an eye on all this and holds the Government to account. Who would you say is responsible?

Lord Bradley: The prisons inspectorate should be taking a view. The lay visitors, monitoring teams who visit prisons and staff representatives should all provide information for which Parliament should hold them to account.

Baroness Lawrence of Clarendon: And presumably the governor.

Lord Bradley: The governor and leadership in a prison is really important with regard to the operational needs of the prison as against the vulnerabilities of people. The autonomy that is likely to flow to governors is an opportunity for them to display real leadership qualities, as long as they have the resources to deliver on this agenda.

Deborah Coles: It comes back to the point about accountability, because the prison inspectorate repeatedly raises concerns about the amount of time prisoners are locked up in cells and the regimes and conditions, as do independent monitoring boards. It comes back to what happens in response to those recommendations. I know the current chief inspector of prisons and the prisons ombudsman have raised concerns about this repeatedly because it is linked to people's physical and mental wellbeing.

Chair: Thank you very much indeed for your evidence and all the work you have done in the past on this. I hope that our report will be able to draw on what you have said to us and take things further forward.

Lord Bradley: Can I make one final comment? We have not managed to touch on community sentences. I am sure that you will look at them, but better use of community sentences for people with mental health and learning disabilities would have a major impact on the prison population.

Chair: There is an opportunity to frame something in the Prisons and Courts Bill. That is what we should all be thinking about. Get drafting.

Baroness Hamwee: Yes.

Chair: You might have to move a new clause when it comes to your House. Thank you very much indeed.

Examination of witnesses

Mike Rolfe, Andrea Albutt, Mike Trace and Mark Johnson.

Q86 **Chair:** Thank you very much indeed for joining us. I know that you have had a chance to hear some of the previous evidence session, so you are all whiskered up to answer the questions we have on this very important issue. I am very grateful that you are prepared to come and give us the benefit of your experience.

It does not appear that we do not know what the problems are: that somehow these deaths are occurring and we do not have a clue why, and what should be done about them. It seems there is a sense of what should be done; it is just that it is not happening in practice.

The Prisons and Courts Bill is coming up. If you want things to happen in practice and you have tried them in guidance, ministerial speeches, proposals, recommendations, good practice and so on, and they have not cut the mustard in making a difference, what does make a difference and is used in other areas is legislation? For example, by law there is a limit to the number of children who can be looked after by a child minder at any one time. There are all sorts of statutory requirements in either primary or secondary legislation that lay down how public services should deal with the people who are in receipt of those services. Indeed, there are statutory prison rules, in that they are secondary legislation but have statutory weight.

Of the things that are a problem and contribute to the tragic number of deaths in custody, what are the key ones that everybody knows should be done and are not being done that could be put into the Prisons and Courts Bill or secondary legislation? Perhaps you could think quite widely about this, including, for example, the ratio of prison officers to prisoners. In general terms, can you say what you think needs to be done?

Andrea Albutt: We need to start from legislation so that mentally ill people do not get sent to prison. Prisons are not places of safety for mentally ill people. To survive in prison you need to be healthy, well and be able to front it out, so vulnerable and mentally ill people should not go to prison. That should be legislation.

That said, I doubt that will be the case, certainly not in the near future; so if we are to send people to prison who have mental health issues of varying degrees, we need to fund a therapeutic environment in prisons where the Mental Health Act probably does apply so they can get the treatment they need and are safe.

Mark Johnson: I completely agree with what has been said. You have heard exactly the same story over the years. Mentally ill people should not be in prison—fact. For me, legislation is partly responsible for the problems that we have now. One example is the IEP scheme and the removal of books and so on from prison. It is a very punitive approach to how we treat prisoners and the impact it has on mental health.

Chair: Could you remind everybody of what the initials stand for?

Mark Johnson: These are incentives and earned privileges. It is quite confusing and complex, but basically if you are mentally ill or you use psychoactive substances, for instance, the fact that you put your hand up is recorded. That can often have an impact, because it will be recorded on the IEP scheme. You could have your TV, razor or anything removed, and it would look like a punishment rather than not. In that case, you would be reluctant to put up your hand formally to a member of staff to get assistance. Basically, “punitive” is “heavy” in mental health and basic access to care. Your stake in your own care has an impact on wanting you to come forward, in which case it creates a subterranean world and existence on the wings where people do not want to come forward with

mental health issues, or how they feel, because they will be treated punitively rather than not.

I do not think that the legislation and the people who make it—I have to laugh—are accountable. The prison staff reduction and prison budget reduction are blatantly obvious when you visit the number of prisons that I do every week. Two wing staff with 250 to a wing say, “Even if I had the skills to be able to do something about this, I physically can’t. I literally open and close the doors”. In the past three months, I have witnessed prison governors opening cell doors and giving out medication to prisoners. Before one of the riots four months ago, I witnessed 260 prisoners putting in an application to access healthcare. Over a three-day period in one particular prison none went.

What anybody says to you about their own little silo of the system, there is a living reality. I was first in prison in 1988, and I have now worked in prisons for the last 16 or 17 years. It is completely different because of mental health issues. A previous speaker referred to personality disorder. We polarise personality disorder but the percentage of people who go to prison for drink and drug-related offending is exactly the same, yet provision for those things is negligible. For me, the situation is blindingly obvious.

Mike Rolfe: One reason why we have seen a deterioration across the board, and not just an increase in suicide and mental health issues not being addressed, is that the operational environment has gone into shock. We see a dangerous, toxic environment in a lot of prisons—not all of them—in the country. That is probably the first failing. They are not resourced properly to deal with anything, let alone mental health, so it is often overlooked. Prison staff are trying to cope in an environment where they are pushed to the limits just to do daily tasks, such as finding a blanket, a bar of soap or a toilet roll for someone. As Mark suggested, often only a few prison staff are unlocking prison wings containing a high volume of people. When they open them, everyone wants a toilet roll and it becomes very exasperating for the staff. They do not have the time that they used to have in years gone by to build relationships with prisoners. That is key.

Whether or not staff are fully equipped to deal with mental health, at the moment there is virtually no training. That is a big issue. Staff are not trained to identify mental health issues. They are not trained to identify a lot of things, including drug-related issues. That is usually done at screening when somebody comes into prison. That is an obvious failing because it is a moving process. People who come into prison without a drug habit might have one by the time they leave. There is this constant need to review individuals, which is not being done. At initial reception a good number of people look at them individually, but once they are put out into the wing environment they are forgotten about. Those prison staff are not adequately equipped to pick up any ongoing issues as they may arise.

Some prisoners might not be assessed as having a mental health condition when they come into prison. They may use drugs while they are in prison, which may lead to a drug-induced psychosis. It is then down to prison staff working on the wings to refer that individual to the mental health services even to have a chance of identifying that person, and, with strapped and scant resources, that rarely happens. One of the big things is making sure we resource those environments properly.

I think prison can work. I see some of the failures that also occur in the NHS. One of the big problems at the moment is that people are allocated to a prison based on the fact they have been sent to jail, not on the basis of their personality problems, their backgrounds and what they have been through in life. They are sent to a set prison and given a set sentence based on the crime they have committed. They are then allocated a letter—a, b, c or d—and sent to a jail that fits the length of their custodial sentence and their categorisation. That does not work for any of them, because for a variety of reasons, not just mental health issues, some prisoners will want to get along in prison, but some will not. Some will want to engage with education and work, but some will not. Probably the same applies to all the different types of prison. They are lumped into one place and all have different needs. Therefore, you are expecting one individual working with them on a wing to have a skillset so vast that it is virtually impossible to do it. They are not professionalised to a level to deal with that.

Perhaps one of the things you can look at on the legislative side is allocating prisoners per their needs. If there is a specific need for a prison that deals just with people with mental health issues, perhaps that is an option, rather than saying that the strain should be on the NHS. These people may continue to offend in the community because of their mental health issues. They may need to be in a secure environment to get access to the support they need, but you may be able to do that in a better way by dedicating a prison to those individuals and having people trained specifically to deal with it in that setting rather than lumping them into the mix with everyone else. Quite often, they are vulnerable people with mental health issues; they are peddled drugs and are subject to bullying. They will be pressured to supply to other prisoners items from the canteen, cigarettes and other things.

Quite often, that is why they are in prison. They have led a life such that they have not been able to secure proper work, perhaps leading to petty crime, or more serious crime, and they end up in prison, but sometimes it is other people who have misguided them in life. These people need protecting not only from themselves but other people around them. If we build therapeutic communities such as Andrea suggested and allocate these people to the right place, at least we have a chance to try to make the right interventions at the right time.

For me, another big issue along with training is professionalising staff to deal with a variety of issues and empowering them as well. Over the past few years I have seen the prison estate become very centralised as an

organisation. There is a blame culture; no one has taken accountability for anything. It has also disempowered the very staff who are absolutely essential to making it all work. The people working on the front line do not feel that they can make individual personal decisions about the people in their group. They are running the environment. In effect, they are running a society in which these people are living, and they do not feel empowered to be able to adjust to their needs because they feel their authority will be questioned, or perhaps they will be accused of acting inappropriately. Alongside that training and empowerment, we need to give people the confidence to deal with the issues that present themselves, and I am afraid it just is not there at the moment.

Mike Trace: I agree with what has been said so far. I had not thought the specific question was about a legislative measure that could help, so I am not sure whether what I am going to say needs legislation or an amendment to the Act, but there is a question about the right to reside in a safe place. Prisoners are effectively in the care of the state, as everybody knows, and there is a responsibility on the state authority to provide safe residence. A lot of what is experienced by most prisoners at the moment is a long way away from safe residence. As previous speakers have said, behind a lot of the suicides and self-harm in prison is the desperation of people who daily live in an unsafe place, which affects them and their mental health.

With that hesitation about whether you want to create a legislative responsibility on the state agency, in this case the Prison Service, what has been underresourced and left unexplored is creating environments of safety in prisons for vulnerable prisoners. We have the whole history of Sections 43 or 53 and prisoners' experience of how well that has gone, or the stigma that creates sometimes. The reality, particularly in times of overcrowding and understaffing, is that in prisons you have the victims and the victimisers. As Mike said, we allocate people largely according to where we can find beds, their security level and the operational needs of the establishment. There are good reasons to allocate on that basis in overcrowded situations.

We do not create in every prison and cluster of prisons the ability to identify vulnerable prisoners, not because they are subject to direct threats but because they are vulnerable owing to their mental health or their own particular situation given their sentence, and give them the option of living in a prison environment that is rehabilitation-focused or support-focused, as opposed to the reality on a normal landing.

In the substance misuse sector—the drug and alcohol sector—in which I work, we call them recovery wings. We say that in any given institution you need to be able to give to a prisoner the option of saying, “I don’t want anything to do with the drug market. I want to be away from it and work on resolving my drug problem”, or, “I’ve never had a drug problem and don’t want to be involved in all that”. I am sure you have heard evidence that there is an awful lot of peer pressure on people who do not want to be involved in the drug market to get involved. That is one way

of creating places of safety, whether it is a landing, wing or, if it is now talked about, whole prisons where people who are transferred there, to say, "We are here to stay away from the drug market and resolve our drug and alcohol issues rather than be pulled in and be part of that market".

The other side of that is the rights issue—the right of somebody in the care of the state to say, "I demand not to be put in a position where I am physically or mentally vulnerable". That was where I paused in referring to legislation, because in a resource-poor and resource-stretched environment, creating a responsibility in our own taxpayer-funded state agency to ensure that every prisoner is in a place of safety is a very big commitment to give to that state agency, prison officers and governors. Therefore, I have some hesitation about enshrining that in law, but operationally we certainly spend far too little time thinking about how we create places of safety and rehabilitation. So, there is something around that but I do not know whether it should be legislative.

Chair: Sometimes the resources flow because there is a statutory obligation. One example, which is perhaps not the best, is 35 hours of childcare for each pre-school child. Resources need to flow to that, because there is now an obligation. Sometimes it can be that way round. You create the obligation and then there is a statutory requirement to resource it.

Q87 **Ms Buck:** I think all of you were here during the first session. I want to pursue questions about the ACCT process, both in general terms and with regard to the effectiveness of information sharing. If it is not effective, what are the barriers to it being effective?

Andrea Albutt: It was quite interesting to listen to the previous witnesses giving evidence about ACCT. ACCT is a really good tool, but we need to talk about why it is not successful in reality. The increase in self-harm and suicides is not all about the ACCT process. It is directly correlated to the fact that we have lost 7,000 prison officers and 500 prison governors, so there is an insufficient number of staff to deliver what is a good process.

We heard from the previous witnesses about families being involved in the ACCT process. I totally accept that culturally speaking prisons are probably not really there yet, but we are not geared up for families to come in to case conferences. To be honest, we do not have the technology in most of our prisons to have teleconferences. Basically, the ACCT process relies on a case manager, who will invariably be an operational member of staff looking at timescales. They will say, "I am due to do the case management of somebody and need to get some people together". It is all done in a very fast and furious way. Suddenly there are people who have collapsed because they have taken NPS and three bed watches have gone out, so the people who were meant to attend the case conference cannot be there, or nurses who were meant to attend are dealing with a crisis in the prison.

This is the reality. This is the way it is. Therefore, the case conference ends up being a tick-box mentality conducted by the case manager and maybe one other person. You might not have a clinical member of staff there or the people who really know the individual, but the box has been ticked and you have had a case conference. It is not right, it is not acceptable, but that is the reality when you have a prison system that is stretched to breaking point. That is where we are.

Referring to the point about legislation and deciding on the staff-to-prisoner ratio, we have a new offender management model that equates to a prison officer having a case load of six people, which will allow them to spend 45 minutes per week with an individual. Even for somebody who is happily trundling their way through a prison sentence happy and well, 45 minutes per week is not very long. If you have somebody who is mentally ill and needs time and attention, they are not going to get it. That allocation of 45 minutes per week will give us 2,500 more prison officers, but we have lost 7,000, and the demographics of prisons have changed; prisoners are more prone to violence. I believe we have more people in prison with mental health issues. It is helpful to have 2,500 people, but it will be interesting to see whether it makes a difference.

Ms Buck: I am keen to know what other people say about this, but I completely accept the reality. Pulling together a team of different professionals must be very difficult. Could any other steps be taken to facilitate better information sharing? I do not want to go too far down the case of Dean Saunders, but the mother had expressed a view on the phone about the high level of risk involved and that did not seem to be conveyed within the system. Even without physically being in the room, should something have been done more effectively to communicate that information?

Mike Rolfe: I think there are inherent problems with the system in place. I know of cases where there is medical-in-confidence. The medical team will interview a prisoner who may give a suicidal ideation but they are not allowed to pass that back to prison staff. In effect, an ACCT document does not get opened on that basis. There are some issues with those restrictions. The medical team is there to provide a service to prisoners but not to support the prison staff. If there was some way of removing those barriers, that might allow for greater information sharing, but even within a prison environment that has 24-hour healthcare, sometimes that breakdown in communication happens. That is a real concern. Prisoners who have taken their lives have perhaps presented that to the doctor who comes in once a day. That doctor has taken the information and kept it as medical-in-confidence but has not passed it back to prison staff, who would then have kept a watchful eye on that individual.

Ms Buck: Because?

Mike Rolfe: Purely because of medical-in-confidence. They say that is information given to them during a private screening.

Ms Buck: Medical confidentiality.

Mike Rolfe: Yes, confidentiality, but there were over 48,000 ACCTs opened in 2016 by prison staff. You can see the complications and logistical nightmare of trying to get families involved with the ACCT document system. Anyone who has visited a prison and does not work there will realise the complications of getting through the prison gate and the amount of time spent getting security clearance.

Ms Karen Buck: It is an incredibly important point. Where there is an issue of medical confidentiality, that is sovereign, is it not? There is no way round that.

Mike Rolfe: Yes.

Ms Karen Buck: The only way to pick up a case of suicidal ideation that is otherwise blocked by confidentiality is by wider family contact and involvement.

Chair: Or the prisoner's consent.

Ms Buck: Either the prisoner's explicit consent being asked for or other opportunities within that environment.

Mike Rolfe: If they have a good relationship with the staff, they will say the same thing that they say to the doctor. Sometimes they will not do that because of the breakdown and fear of the stigmatisation that we spoke about previously. Being the subject of an ACCT document, especially if you are sharing a cell, requires a prison officer to knock on your glass every hour to check that you are all right. If you are sharing a cell with two other people, they will become very upset during the night when they are trying to sleep if a prison officer is banging on the glass every hour. Sometimes it is the simple practicalities that stop people wanting to present themselves.

It used to be that a lot of those who took their own lives would never present to staff as suicidal anyway; they would always stay very well hidden. It was only because of good staff relationships with those prisoners that they would even pick up that the person might be a bit low or a bit different today, or that he had had a family call that had gone wrong. Because of the prison environment and breakdown in relationships, now staff will unlock and may retreat because violence is so extreme. You do not have those personal relationships going on. That is the real key issue in all of this. If those personal relationships existed, people would pick up things. It is human nature.

Ms Buck: You cannot legislate for personal relationships.

Mike Rolfe: You cannot.

Ms Buck: Clearly, that brings us back to a certain extent to the question of resources.

Chair: But you can, of course, legislate for the ratio, and you are saying that the personal relationships are undermined by lack of ability.

Mike Rolfe: Yes.

Q88 **Chair:** Karen asked about ACCT. I completely understand your point that sometimes they do not happen when they are supposed to because something else calls people away, and it is difficult for families to be there physically and you do not have the technology, but if I want to have a call or be involved in a meeting when I am not there often people will be on a mobile phone and put it on speakerphone. Can the families not join in on that basis? It is not like the Pentagon where you have to have screens up.

Andrea Albutt: No, absolutely not. Most of our ACCTs occur in remand prisons. Most of the prisoners with mental health issues are coming straight from outside into remand prisons. In some of our old Victorian prisons—you cannot bring a mobile phone into a prison, obviously—generally there are no speakerphones.

Chair: You mean that the staff cannot bring in a mobile phone.

Andrea Albutt: No, it is illegal, but we do not even have speakerphone technology in prisons, so it is really challenging. We heard about technology in Thameside prison. It is an unusual prison in that it is new and is built with technology. Most of our prisons are not new; they are old and suffer from underinvestment. To do things that in this room sound very simple and basic are logistically very difficult in prisons.

Chair: Do you think it would facilitate engagement with families with an ACCT? Do you think the idea of having a mobile phone that can be put on speaker is a sensible solution, while we wait for all the other technology to be sorted out?

Andrea Albutt: Yes, of course.

Mike Rolfe: I think it could cause some issues, because a lot of prisoners have bad relationships with their families as well, although their families may care about them.

Chair: Sure, but only if they have given approval, and those are the guidelines anyway. It is not up to the family despite the prisoner's wishes; it arises where the prisoner has given authority.

Mike Rolfe: Yes. I think it could overshadow the work. For instance, if you have a very worried mother on the phone in those circumstances trying to press for what she believes might need to happen in the prison environment, that is removed and detached from what is going on while the individual is in there.

Chair: Except that in the case of Dean Saunders and his absolutely worried mother, it is what would have stopped them going from twice an hour to every 24 hours, which sadly provided the opportunity for him to kill himself.

Mike Rolfe: It would have been a key component, yes.

Andrea Albutt: To be quite honest, it would be very easy to have families involved if we had properly resourced mental health units. We have safe custody officers, but it should be properly resourced so that you have people whose role it is to liaise with families and mental health teams. It could be a kind of department whose role is about helping people who have mental illness.

Chair: You are talking about stability and functionality.

Andrea Albutt: Yes.

Chair: You need a level of stability and functionality before any of this can work.

Andrea Albutt: Yes. I am referring to people who know their role and job description and what they have to do. If we were able to do that, we could facilitate families' access to their children, or whoever, in prison. One could organise and guarantee that on this day at this time there will be an ACCT review of whoever. If we resourced that, we could do it.

Q89 **Baroness Hamwee:** You heard the earlier discussion about lessons learned and so on. From your own experience as a governor, when recommendations were made by the coroner or ombudsman how would you respond? How would you follow up?

Andrea Albutt: Together with HMIP, you would develop and deliver action plans. I hate to keep going back to resources, but I cannot overemphasise how challenging it is in prisons under austerity measures. You would have an action plan and attempt to deliver it, but because we have moved to a very centralised model—I put this in the submission—governors are working with their hands tied behind their backs. There are inadequate resources. Usually, the recommendations will involve some kind of resource to deliver them, or the resources are not held by the governor but are held centrally, whatever it might be.

It has been incredibly difficult for governors to deliver these action plans, coupled with an operating environment that is so challenging and unstable. Particularly in our remand prisons, governors are trying just to keep the lid on prisons. Unfortunately, things like action plans go on to the back burner. They are trying to unlock prisoners on a daily basis, because regimes are limited and it is so challenging.

Baroness Hamwee: This question probably shows how naive I am. Is there no scope for saying, "We have had recommendations to apply some new arrangement. Is there anything somewhere else that can give to allow this to happen?"

Andrea Albutt: Back in, I think, 2013, a benchmark model was applied showing how much it costs to run this type of prison. It was basically one size fits all. At that point governors were saying, "You spend so much on this and so much on that". There was no autonomy over your prison budget. It has been proved that that benchmark was inadequate to run

prisons. You could not really rob Peter to pay Paul, because your budgets were at critical levels.

Baroness Hamwee: Do individual prison governors get any opportunity to make representations going up the ladder, as it were, about the importance of action plans, recommendations and so on?

Andrea Albutt: I think prison governors do this all the time, but when you have government austerity measures it is very difficult to bid for very limited resources.

Chair: Is what you are saying that it is basically a level of crisis management with inadequate resources?

Andrea Albutt: Yes.

Chair: On that basis, whatever good ideas people have for preventing suicides it will not happen, so the level of suicides will carry on and get worse.

Andrea Albutt: Yes. You can talk about the leadership of the governor, which is absolutely critical, but if you are running a prison you might be 30 or 40 prison officers short and trying to run some kind of decent regime, but on a daily basis you are running a red regime, which means people are locked up most of the time. You cannot think about cultural change and leadership, because it is quite overwhelming.

Q90 **Baroness Prosser:** If we come back to safety for a moment, you will have heard Harriet say earlier that one of the things that we want to do in our report is make recommendations about how things ought to be better in the future. According to the Ministry of Justice's report on assaults in custody, in the year up to September 2016 there were over 25,000 assaults in prison. Whatever way you look at it, that must be considered unacceptable in a so-called civilised society. What do you think could be done to help prison officers and leadership from the governor to enable those officers to be trained better to deal with issues arising from people who are mentally ill? A lot of that must make life hugely unstable because you do not quite know what is going to happen next. What sort of training do you have now?

Mike Rolfe: Training is 10 weeks at the moment. You do a week of C & R training, which is control and restraint. Andrea has touched on it. A lot of this is about resource. On some days, we have wings where three prison officers are opening up 150 prisoners. You will get angry, aggressive prisoners who spend a long period behind doors, only for them to be opened up so they can be given a sandwich or medication and the doors are shut again. A lot of this is about resource. Prison officers develop those skills over time by working on the job. The training for me is an ongoing two-year period. In the first two years of being a prison officer, you learn how to adapt your skills to manage large groups of people without any real weapons. The only thing you have is a baton, which would not deal with anything. To deal with violent people you have to

learn interpersonal skills, because a lot of these prisoners are big, strong, physically powerful guys.

Baroness Prosser: Are the interpersonal skills part of the initial training?

Mike Rolfe: Not really. It is a 10-week training course that is meant to prepare you for all the things you might see, but it does not prepare you in reality for life-changing experiences such as someone taking their own life. The first time you find someone dead it is quite shocking and terrible. If you have not come from that family environment, the first time you open up and go into a cell where blood is spurting everywhere from somebody's arm is quite shocking and terrible. The first time you see prisoners fighting and realise it is over a chocolate bar you think, "My God, how ridiculous is this situation?", but that is the reality of prisons.

You need a good number of prison staff, but the learning comes with the job and it is all part of the training. There should be ongoing, continued support and development. A good prison officer will adapt skills from experienced staff. They will say, "I like the way that guy handled that situation. I will try to mould that and use it in future". But at the moment the environment is literally that you unlock the cells, you are bombarded by a lot of angry and upset prisoners, and you retreat as far away as you can. That has completely broken down any of those relationships.

Baroness Prosser: Do you have many experienced staff still there, because there is quite a big turnover?

Mike Rolfe: Andrea touched on the situation in 2012. That was when they ran a VEDS programme to get rid of high-cost prison staff who were full of experience. They looked to remove those and bring in new staff at a considerably lower wage. Of course they did that. With no disrespect to the new staff, they had no mentors to learn from, so a lot of the jail craft disappeared at the same time and it led to the breakdown of the environment in prisons. You lost a lot of experience and demotivated the staff you had, because at the same time as you got rid of staff and brought in new and much cheaper people, you increased the pension age of those currently there and froze their salaries. Of course, you had a very demoralised group of experienced staff, who needed to pass on that experience but did not feel empowered to do that.

Rather than focusing on having prison staff dealing with situations, it became very removed, remote and centralised. As I am sure Andrea will attest, prison governors felt they had no control over what they were doing in their own prisons, just as prison officers did not feel they had any control over what they were doing when working on their wing.

Some prison officers would punch a prisoner on the arm as a joke; it was a friendly exchange. Now they would be accused of assaulting the prisoner and be out of the door in a second, but to live in that environment you have to adapt to how you would be at home and bring that into your personality and into the role. That is how you control large

volumes of people without the threat of violence: you do it through a skillset and developing relationships. Some of that is about having a joke and a laugh; some of it is about making it feel like a home environment, but all that was taken out. I absolutely agree 100% that we have to be in a professional environment, but you have to build those relationships.

Q91 Baroness Prosser: The Committee heard last week about resuscitation. The people giving evidence expressed the view that prison officers seemed to be very afraid of resuscitation as though they did not quite know what to do and panicked. Can you give us your view on that? I will come to you in a minute for the governor's view of this.

Mike Rolfe: Prison staff are scared to do a lot of things. They are afraid of litigation and that charges may be brought against them. We have had instances where staff have not involved themselves in resuscitation. First, they are not necessarily trained. Secondly, even if they are they feel that perhaps they should not do it, because they might be accused of something. There is also fear and lack of knowledge about whether you will get a communicable disease if you try to resuscitate that person, or you have not been given the equipment to deal with what is in front of you. They usually pick up a radio and call for healthcare to attend as soon as possible and state the level of the emergency.

Andrea Albutt: Prison officers are not necessarily trained in CPR, so if they are not trained they would not be expected to do it. You could also be trained but never use it, so when the time comes for you to do it you do not feel confident about it.

Lord Woolf: Is there any incentive for governors and prison officers to get additional skills and qualifications?

Mike Rolfe: We are looking at that with the employers at the moment; it is something we have pushed quite heavily. At the moment, there is no incentive to take on additional voluntary duties such as first aid or emergency resuscitation.

Andrea Albutt: I think it would be quite good for all members of staff, or prison officers, to be trained in emergency first aid and resuscitation, but they would have to have regular refreshers, because it is not something you use all the time. Certainly in some prisons you would never use it.

Baroness Prosser: I get the impression from what you are saying—correct me if I am wrong—that it would be quite good, but you do not see it as the next thing on the list that must be attended to.

Andrea Albutt: No.

Q92 Lord Woolf: Where do we start to reverse what has been happening? Twenty-five years ago I did a report on Strangeways. I now see things that are worse than they were 25 years ago. We thought then that it was terrible. Where do we start to get back? We have a new Act coming through. The Government are not blind to the fact it is not working at the moment. Where do you say they should start?

Mike Trace: How we reverse the cycle we have got into is exactly the right way to frame the question. Over the 30 years you talk about there have been a lot of improvements in the management of prisons, professionalisation and that sort of thing, but we have got into a cycle where staff to prisoner ratios are so difficult that everything else becomes negative. I agree with everything I have heard here. As to conditions in prisons, we are in a cycle where the ratios, resources and the estate are not good enough, which leads to more anger, despair and challenging behaviour. That cannot be resolved because there are not enough staff and resources, and so on. It is a cycle, and it will get worse.

The unfortunate situation is that the first answer to the question is that you have to change the ratio. There are only two ways to do it: many more staff or many fewer prisoners. That underpins everything.

Lord Woolf: Or both.

Mike Trace: Yes, but neither of those is easy to achieve politically or practically. We are in danger of repeating ourselves, but that underpins everything else that we say. When I talk to governors I generally say that we have what we have: the staffing limitations and the realities of the resources. What is within our capacity is to create more prosocial environments within prisons. Once again, it is very difficult to do with staffing limitations. In a lot of the prisons where we work, it is fair to say that the staff are not in control. There are lots of wings and landings where, as you say, the staff are stepping back and stepping away, and what fills that vacuum is the worst type of prisoner. I do not want to generalise, but that is usually what happens. The most powerful and the nastiest guys will fill that vacuum. That is a cycle of despair.

What has not been written about much is that behind a lot of these suicides, self-harm and acts of violence are people—prisoners, not staff—who are at the end of their tether. We have to break that cycle somehow. If the authorities are not going to reduce significantly the number of prisoners, and the number of staff is not coming up to the level that anybody agrees will change the reality, we have to find ways to create positive environments, maybe on one landing or wing or maybe on two wings. There are some plans now about creating therapeutic prisons. That is where we ought to be focusing our creativity within what—I agree with every other speaker—is an unreasonable restriction on resources. You cannot change this cycle unless the resource realities are changed.

Mike Rolfe: I agree with a lot of that. I work in a remand prison. A prisoner is sent to jail and next day he is visited by about eight or nine different people from all different organisations to do a tick-box exercise. That job used to be done by prison officers. On the first day they would say, "Do you need education? What are you like for housing on the outside? Have you got a drug problem?" That helped to build some of the relationships at the time, because when they come into prison the first person they see is that prison officer. What they have done is remove all those roles from the prison officer and all he does now is unlock or lock that person up.

Lord Woolf: Who performs that role now?

Mike Rolfe: Lots of civilians or voluntary organisations come into prisons now. Some of that resource money could be reapplied, so it would be without additional cost, to put more officers on the landing to do that work with prisoners. We give them some of the engagement and relationship build-up to start with.

Lord Woolf: And the responsibility.

Mike Rolfe: Yes. It may start someone on the right footing in their prison journey rather than the wrong footing with prison staff when they are unlocking. The key is to give them those roles to work with prisoners that might break down some of the barriers.

Andrea Albutt: We are talking specifically about local prisons. I have governed four local prisons and know exactly what they are like. When they come into reception we will do assessments; we will get information and do all these different things with them. That is probably the worst time to do it, because people are coming into prison absolutely fraught. They are petrified, they have probably had a very long day in court, they might be coming into the prison at 7 or 8 o'clock. For the nurses doing the assessment it is like a conveyor belt, one after the other again and again. We need to get them on to the wings so we can get them locked up because the evening is approaching. Our reception process is not a calm experience for men and women when they first come into prison. If we are going to do an assessment, we will probably not get the best and most accurate one from a very fraught person, particularly somebody coming in with significant mental health issues.

Q93 **Amanda Solloway:** I was interested in something you said earlier. There are examples of prisons that are still managing to deliver to targets. What do they manage to do that clearly prisons that are failing do not?

Mark Johnson: Having worked in 24 prisons, some of the best examples I have seen in the current climate—I am not sure you have heard about this yet in your Committee—are those where prisoners see themselves as stakeholders. Some of the best practice I have seen in dealing with a lack of budget and with conditions arises where prison governors promote more responsibility among prisoners and pick up that thread: listener schemes, councils, and healthcare runners.

When you put yourself in the shoes of somebody who is self-harming or on the edge, as Mike said, it is often another prisoner you want to talk to more—there is a lot of research on that as well—because of the power dynamic and the risks of being recorded and seen as vulnerable, and maybe being bullied as a result of that. A lot of the transactions that take place cell to cell are done by prisoners. It is the same situation with staff and resuscitation. There is a lot of reluctance on the part of prisoners and staff to get involved.

Chair: I am sorry. The Commons members of the Committee need to go and vote. We will be back shortly.

The Committee suspended for a Division in the Commons.

Amanda Solloway: I do not know whether I put my question very well. There are some examples of well-run prisons given the same resources.

Andrea Albutt: I know that I sound quite negative, and as has just been pointed out we also need to sound more positive about things. So I will sound more positive. We have some really good examples. I have governed women's prisons too, and there is a completely different culture there. To go back to the point about the benchmark staffing levels, they got extra resources, whereas the male remand prisons got less. There is a very good culture in women's prisons of care and wanting to do the best. If you go into a women's prison and a male prison, they are like two different services.

The difference is unbelievable. There is warmth in the culture. Instead of the culture in male prisons, which is more about "them and us", in women's prisons everybody is in it together. I think we can learn to encourage male prisons to be softer and more caring. Then you would probably be able to see and hear more of the issues.

Amanda Solloway: I understand what you are saying. I have been to a few prisons. I am thinking of a male prison as a good example, but from what is coming across I am concerned about behaviour and attitude. You are talking about the need to be more caring. What care is shown? That is free; it is just a change of attitude. I am concerned that however much you put in more resources, that behaviour and attitude does not change just because you have more people. As Mike said, if you give people two years, you can train them to be like other staff, but that is no good if the attitude and training is not good in the first place.

Mike Rolfe: You are assuming that there is a bad attitude at the moment. I do not think there is. I think there is an attitude at the moment—

Amanda Solloway: I am just going on what Andrea said about care. Let Andrea come back first.

Andrea Albutt: In women's prisons there is not the same level of violence. They are not as dangerous as male prisons. I have to agree with Mike that in some male prisons the level of violence towards staff is unacceptable. Clearly, that impacts on the relationship between staff and prisoners.

Prison officers are trained but they are human beings. If people are being violent and aggressive towards them it is quite scary, no matter how well you are trained. Clearly that will impact on the rehab culture and positive relationships, and that is where we are. If we had more people, it would give staff the confidence to know that there is sufficient to start working specifically with men in prison to build dynamic relationships and get that rehab culture in place.

Amanda Solloway: When you refer to enough staff and fear, I assume

you are talking about fear of violence. Are you therefore talking about needing enough staff to restrain?

Andrea Albutt: I am not saying that you need enough staff to restrain, because restraint has to be absolutely the last thing. You need sufficient staff so that they feel confident about having challenging conversations where they need to, and they see deterioration in behaviour, particularly with mentally ill people. If they see the deterioration, instead of reacting to the crisis maybe they can prevent it so that the whole thing will stabilise. Then you start building trust and relationships. If you have trust and relationships, prisoners are less likely to be violent and aggressive, staff are less likely to respond with restraint, and you would have a calmer prison setting.

Mike Rolfe: Empowerment comes into this a little bit. I was trying to touch on this earlier. Prison officers are working in the toughest environments, whether they are male or female prisoners. Most people are inherently caring. It is human nature to come into a role and try to be caring. I see that with a lot of people when they first step through the door; they become desensitised to the environment they are set up to deal with. They continually see the negative portrayals of the society they are working in impacting on them. They do not feel that anyone supports and cares for them. We need some initiatives to mentor and support staff, but you also need initiatives to mentor and support prisoners.

Some jails work because they are small, niche establishments that usually cost a lot of money per prisoner place. You will know that the coalition Government in 2011 closed a lot of jails that were quite high performing but very expensive. Latchmere House is a prime example. It had a reoffending rate of less than 5%, but they closed it because it was extremely expensive.

Lord Woolf: It would not be really expensive if they thought about the costs of reoffending. In that sense, Latchmere was a cheap prison.

Mike Rolfe: In the long term, yes. This is sometimes the problem with politicians overseeing public bodies. Because political careers are short-lived, if you are the Secretary of State and you want to make a name for yourself and be seen as robust, challenging and changing things, you will bring out a whole sweep of new ideas. We see the Prison Service having constantly to adapt and change every time there is a new Secretary of State. They have taken us in a different direction every time. That has been extremely unhelpful. Legislatively speaking you could allow the Prison Service to run itself and have the right people appointed by Ministers, but they are left to get on with the job.

Amanda Solloway: I understand the point about government changing, but I suggest that leadership has an integral and important part to play. Surely that would be static throughout those changes.

Andrea Albutt: Do you mean leadership of the organisation or the prisons?

Amanda Solloway: The prisons, because we are seeing individual standards. I can see Mike nodding at the end.

Mike Trace: The start of your question was about setting an institutional culture. That was what I was thinking about earlier. Within whatever resource constraints we have—there will never not be some resource constraint—setting an institutional culture is our room for manoeuvre. We are caring for a group of people, whether it is 1,500 people in Wandsworth or 50 people in Latchmere House, which is quite small.

The room for manoeuvre a leader has is to create an institutional culture. You can do quite a lot with inspirational leadership by mobilising the positive aspects of whatever institution, even prisons. In any prison among the staff workforce there are amazing, inspirational, great people, and less capable people. A good leader will mobilise the best in that, and I think Mark is quite right. A lot of the changes to prison officers' roles over the past five to 10 years have inhibited the ability to bring out the best.

Good leaders will also mobilise the best of the prisoners. There is a battle on every prison wing and landing between the guys who want to do drugs, victimise and be violent, and other guys who want to do their time, get by and make some progress in their own lives. Right now, we have a culture where the first set of guys is ruling, absolutely. We have to create a culture where the other guys are mobilised.

Leadership is a large part of that. I am sorry to go back to it. You can have all the leadership you like, but if you have two officers and 150 prisoners you will not win that.

Baroness Lawrence of Clarendon: Earlier we talked about human rights and the obligations of prison authorities in relation to the right to life. How would you define what a human rights-based approach means in practice, for example for prison officers, prison governors and prisoners themselves?

Andrea Albutt: When you say "human rights", what do you mean?

Baroness Lawrence of Clarendon: All individuals have the right to life, whether they are in prison or outside it. The question I am asking is: how do you as a prison authority approach what it means in practice for the prison officers, the governors and prisoners themselves? What does it mean in practice in terms of human rights?

Andrea Albutt: In a prison, we have to provide an environment that is safe, decent and meets the needs of any individual who comes through its door, so that if you have somebody with mental health issues, to whatever degree from a human rights perspective we can manage those issues.

Mike Trace: This is not prison-specific. Some of the rights that we have enshrined in Europe and that we will have in whatever UK human rights Bill we devise are very relevant to prisons. The question for the

Committee and Parliament is: how strongly are those rights enshrined in prison rules? You talked about this earlier. The ones that jump out to me are the right to life, as you pointed out; the right to privacy; and the right to self-determination. In all those there is a balance to be struck, because people are in the care of the state. There is a certain limitation to their privacy, self-determination and, as we know, right to life, but it is conceptually possible significantly to strengthen prisoners' rights linked to human rights legislation. Coming back to our previous point, that changes the game, because as soon as prisoner rights are strengthened under those headings—I can see some downsides—the institution has to find the resources and ways of working to meet those standards. Therefore, that can be a game changer.

- Q94 **Chair:** The final question is about drugs. We have heard about the cuts in prison officer numbers as a new trend that is exacerbating the situation. Is there a significantly new trend in relation to the availability of different sorts of drugs in prison? With all these new psychoactive substances, is that making a marked difference in exacerbating mental health problems?

Mark Johnson: Absolutely. When we did the report on Spice, we worked with about 1,000 prisoners. It identified that one in three were daily users of this new substance—there is still hardly anything known about it—which is anything from carp food to an unknown chemical that comes from China, which is similar in molecular structure to cannabis but is definitely not cannabis. To suggest that it is even remotely similar is wrong. Nobody knows the consequences for somebody using it. The predisposition to psychosis is massive and it does not get picked up anywhere.

It is probably worth raising a little flag that, because there is no test that is fit for purpose, it would not be picked up in a coroner's report. Prison governors or security officers know that certain people are using this substance. In two instances I know of, the person died, but it was not on the coroner's report because it was only a suspicion.

The long-term implications for people exiting prison are unknown. For me—I am unqualified—the evidence, anecdotal or whatever, is that this is a ticking time bomb, and it is one of the big issues behind your inquiry. You are talking about prison safety. People in prison use predominantly cannabis. Wherever you lock somebody up and remove hope, they have a desire to change how they feel. There is a logic to it.

Mandatory drug testing was introduced in 2010. I feel that legislation needs to be reviewed, especially now in this critical environment. Cannabis stays in your system for 30 days. You are predisposed to mental health problems as a result of cannabis use. That is a fact. Cannabis stays in your system for 30 days, so a prisoner having a drug test would have to wait 30 days to flush his system out and there is a likelihood of being caught.

Heroin will stay in your system for two days, so you could have it on the Friday and flush it out of your system by Monday. There is evidence of how many prisoners go into prison as non-heroin addicts or drug users and come out heroin addicts. I think that is widely known. Spice comes along and there is no test that is fit for purpose. There is talk of developing something, but because of its molecular structure it changes to such a degree that each break in it creates 200 or 300 different brothers and sisters, so you would need a new parameter to test it. People use Spice because, as it says in the report, it is the bird killer; it kills time. They take high risks with their long-term mental health because they need to get off their heads. A really good quote that is used, if you excuse the French, is that a shit feeling is better than no feeling. That is some of the picture behind it.

We could stop MDT—mandatory drug testing. We could do something different, yet an investment of £15 million in sniffer dogs has been announced. It is not the cause of the problem; it is a symptom. For me, it is poor decision-making when we have to get to the root of the problem of why people are taking these massive risks with their long-term health.

Chair: Thank you very much indeed for the evidence you have given to us, which has been extremely powerful.

Baroness Lawrence of Clarendon: Before we finish, you have talked about all this. What do you think needs to happen for the powers that be to hear all this and make the changes? Obviously, something needs to happen. You referred to drug taking. Whom do you need to have in front of you so that you can talk about having those changes?

Mike Rolfe: As a trade union, we have tried every avenue, even to the point of taking industrial action. Thank us for that or not. I know everyone will have a different opinion, but it was to raise our concerns because no one was listening. We banged our head against a wall with the senior leaders in the department but also with Ministers at the very highest level. We said that we needed more staff and to do more about it. They have reacted probably on the back end of a lot of what we have been trying to do, but we do not want to behave in this way. We want to be a responsible trade union and work with these people, but when they are not listening to the problems and key concerns, which you have heard from every one of us here, we make a difference by having the right resource in place. We felt that we were pushed into a corner.

I think we have tried everything we can in response to that question. We will continue to push that argument. I am sure my colleagues here will try to push the same argument, although probably in different ways from ours.

Jeremy Lefroy: I had one of your members at my surgery on Friday from Brinsford. He made a lot of the points that you have been making to us very eloquently today. By the way, he was somebody who really loves his job and is one of those experienced officers who makes an effort to communicate with prisoners.

On the issue of drugs—Spice and so on—I absolutely see the need for more staff. That is a sine qua non. You talked about removing mandatory drug testing. Why would that help?

Mike Rolfe: I tend to agree and I am a prison officer. I think we should be tackling drugs within a prison. We should be stopping them coming in as best we can. You will never completely stop it, but there has always been an inherent drug problem in prisons. Nine out of 10 times, the people who use drugs have either suffered sexual abuse in their childhood or have had a terrible upbringing. They use it to disclose and hide things. When they are in prison it is no different. They are in prison and want to forget about what has gone on in their lives. They are now in prison and want to forget about that at the same time as well.

The only way you will deal with it is by dealing with these people's social issues that they might never ever want to talk about. Some people will use drugs for life until they die. That is the unfortunate truth. We have that experience in jail very often. It is never pleasant, but some people will continue to use drugs regardless of whether you charge them and impose additional sentencing, but the prison system has forced people into using particular drugs through MDT, which is a failure in itself.

Lord Woolf: I think you have to explain that they are forced into it, especially if they use Spice, because the fact they have taken drugs will not be detected. First, they used cannabis, which could be detected, so they stopped using it and used heroin, which can still be detected but only for a very short time.

Mike Rolfe: I do not think we can ever condone the taking of drugs, but you are absolutely right that people used to use cannabis but it stayed in the system for a long period of time. You would bring charges against them, but these people probably need better help than they are getting to steer them away from drugs. That is done through education and giving them opportunity. We are not doing that. We are condemning people and releasing them back on to the street so that they fall back into what they know best. For some who come into prison they feel worthy. This will sound a bit perverse. They will be sleeping rough on the streets. No one will talk to them and they will be scrounging for money, food or whatever. When they come into prison, suddenly all these people want to interview them and tick a box. They see their friends and it feels like a society they want to be in, so how do you change that without giving the right opportunities on release? You will never change it otherwise.

Chair: You have been incredibly helpful in painting a picture of the scale of the task to be faced. We are really grateful to you. Thank you very much indeed for your evidence.