HOUSE OF COMMONS

# Health and Social Care Committee

# Justice Committee

## Oral evidence: Prison health, HC 963

Tuesday 3 July 2018

Ordered by the House of Commons to be published on 3 July 2018.

Watch the meeting

Members present:

Health Committee: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Diana Johnson; Johnny Mercer; Andrew Selous; Derek Thomas; Dr Paul Williams.

Justice Committee: Ruth Cadbury; Bambos Charalambous; David Hanson; Victoria Prentis.

Questions 1 - 120

### Witnesses

I: Sean Cox, Head of Development, User Voice; Hazel Alcraft, Development Officer, Health, Clinks; and Stuart Ware, Chief Executive Officer, Restore Support Network.

II: Rebecca Roberts, Head of Policy, INQUEST; and Elizabeth Moody, Acting Prisons and Probation Ombudsman.

III: Professor Steve Field, Chief Inspector of General Practice; Jan Fooks-Bale, Health & Justice Inspection Manager, Care Quality Commission; Peter Clarke, Chief Inspector of Prisons, Her Majesty's Inspectorate of Prisons; and Paul Tarbuck, former Head of Healthcare Inspection, Her Majesty's Inspectorate of Prisons.

Written evidence from witnesses:

– User Voice

- Clinks
- Restore Support Network
- INQUEST
- Prisons and Probation Ombudsman

- Care Quality Commission
- Her majesty’s Inspectorate of Prisons

# Examination of witnesses

Witnesses: Sean Cox, Hazel Alcraft and Stuart Ware.

Q1 **Chair:** Good afternoon. Thank you very much for joining us for the Health and Social Care Select Committee inquiry into prison health. We are delighted to be joined by a number of members of the Justice Committee, who are conducting separately an inquiry into the prison population 2022. A number of Members will be popping back in shortly—they have had to leave the room for a few moments, so excuse them if it seems strange that they appear in about five minutes' time.

For those who are following from outside the room, could you start by introducing yourselves and who you represent?

***Stuart Ware:*** I am Stuart Ware. I founded a charity called Restore Support Network, which is for older people in prison. That was back in 1996. I came out in 1997, when I was 59; I was an older person then, so guess my age now, but I am still going. It is a peer support group. It offers support to older people in prison and when they are released, particularly when they are released and in the community.

***Hazel Alcraft:*** I am Hazel Alcraft. I am the development officer for health and justice for Clinks. Clinks is a national infrastructure support organisation for the voluntary sector working in criminal justice across England and Wales. We support and represent over 500 member organisations and a wider network of around 2,000 voluntary organisations that work with people in criminal justice.

***Sean Cox:*** I am Sean Cox. I am head of development for User Voice. User Voice was set up 10 years ago by our founder, Mark Johnson. It is currently the only user-led organisation in the country. We deliver services up and down the country in prisons and in CRC contracts, as well as doing consultations for bespoke pieces of work. We are pretty much user-led all the way through the organisation. We employ about 60 staff and 97% are ex-offenders, people with lived experience. We pride ourselves on using those with lived experience to work for us.

Q2 **Chair:** Thank you. Starting with you, Sean, could you set out for the Committee what the key risks are to the health of the people you represent in prison?

***Sean Cox:*** Part of our role is to work with service users who live in the criminal justice setting. We deliver health councils in 15 prisons in the Kent, Surrey and Sussex area. We are very much focused on hearing their views about what they feel they need or perhaps are missing in the current health provision in prison settings. The key ones they are coming up with at the moment are lack of drug and alcohol treatment, lack of mental health resources, time restrictions on seeing GPs and seeing them in a timely fashion, and dentistry, which in the prison setting may not be equal to what is out in the community.

For the individuals we represent, the risks are perhaps going back into the community with an unaddressed drug and alcohol problem, so they may return to drug using on release; and not having some of their main healthcare addressed, such as some of their physical and mental health needs, which will contribute to reoffending. Obviously, if, while you are in custody, your emotional wellbeing is not dealt with, and you are alone and isolated, it often contributes to self-harm and will contribute to the risk of increasing deaths in custody as well.

Q3 **Chair:** Thank you. Hazel, is there anything you would like to add?

***Hazel Alcraft:*** We certainly recognise all the risks that Sean outlined. It is worth bearing in mind that prison healthcare does not exist at all in isolation. People who are very unwell are being held in a prison system, an environment that is primarily designed around security and managing risk and not conducive to promoting health and wellbeing, so there are elevated risks to mental health. Suicide, self-harm and potential drug use can be caused or exacerbated by the prison environment.

It is worth highlighting the link between substance misuse and mental health; they very often co-exist, and many people in prison have problems and challenges with both. One of the things our members often say is that it can be very difficult for people who have a substance misuse problem in particular to access mental health support, which can make it more difficult to treat and deal with either of those issues.

***Stuart Ware:*** Our concern is mainly with older people with multiple and complex needs. I have to say that, as you get older, they do get complex and multiple. In prison, our major concern is lack of out-of-cell activity for older people. If they are in a mixed-age group in a prison, the younger ones sometimes take the focus and the older ones have to take second place; they are often banged up for many hours, and I know myself that if you do not exercise, use your limbs and get out-of-cell activities, you start to seize up. All of them come out in the end, but with a few exceptions, they come out with more complex and multiple needs, which have to be faced by the community. That is our major concern at the moment—the overcrowding and the lack of activities on the wings in some prisons.

There are some exceptions. There is some good practice in some prisons, but it varies from one prison to another. There is lack of consistency. An older person could be transferred from one prison where there is good care and support, as well as their health and social care needs being met, to another prison where there is almost nothing. That is one of our major concerns.

The other concern is short sentences. I know they have been in the headlines. There is a growing number of older people getting short sentences of just a few months—less than 12 months. They have multiple needs before they go into prison. They come out and there has been no time for their needs to be met. The rehabilitation programme cannot kick

in, and when they go out they meet even worse conditions. Often, they get into a cycle of minor offences and go back to prison, still with their care needs. One of our concerns about that is that each agency has a service, but they are single focused. There are partnerships at a higher level, but at local level, they are single focused, so social care services may not have connections with local probation and so forth. There is single focus and a lack of interaction.

Q4 **Chair:** Thank you. Sean, to add to your list, one of the things that was raised with us by the people we spoke to at Thameside was the lack of prison staff availability to take them to NHS appointments outside. Is that something you are hearing from your group as well?

***Sean Cox:*** Yes, absolutely. It is fair to say that everyone is aware of the prison staff shortages across the estate, up and down the country. What tends to happen is that each morning the governors do a bit of a roll check of their own staff for that day; if there are routine external hospital appointments that prisoner A or B has to attend and the prison does not have enough prison officers to escort them, they cancel those appointments.

**Chair:** That has been raised with you.

***Sean Cox:*** Yes. The priority for them is to ensure that the prison is safe, and that they have an adequate number of staff there, so, yes, routine appointments get cancelled. Emergencies will not. Anything that needs a 999 call for an ambulance to come in will take priority, but routine, everyday appointments would get cancelled.

Q5 **Diana Johnson:** You have already mentioned, I think, some of the problems with access to healthcare. Could you say something about problems in the quality of healthcare provision and if there are examples of good practice that we ought to be looking at and be aware of?

***Sean Cox:*** When we summarised our report to the Select Committee, when we gave written evidence, we said that about 99% of the prison population need to access healthcare services of some description. Pretty much 100%—everyone coming into the custodial setting—need some type of healthcare, and 72% highlighted poor access to healthcare. I do not think the blame is necessarily with the healthcare providers themselves; it is more about the infrastructure of the prison estate, with officer shortages and how the prisons are laid out.

Some of them are Victorian, which sometimes makes it harder to get from A to B. We mentioned the older generation population being able to get transport from A to B. A person may need a wheelchair and a prison escort, which then means more resources from the main lot of officers. Staffing issues contribute, so I do not want to say that healthcare providers are bad as such, but 53% of the prisoners we interviewed said there was a poor healthcare service. Some of that is compared with what they expect to receive out in the community; you might expect to see your GP within 24 hours after making an appointment. That may get

delayed in the prison setting partly because of being unable to get a GP to come into the prison, for example, on a few occasions, or it may be purely the fact that there are not enough officers to be able to get people from wing A to the healthcare unit, so it becomes a bit of an operational issue.

We do see some good practices—absolutely. People really praise some of the work and dedication of staff who work in a very difficult environment. Even prisoners recognise that it is a tough environment for anyone to work in at the moment, so they praise the staff and say that they still commit 100%. There is some joint working between healthcare providers; they realise that the regime is so tight that they have limited time to see everybody, so they tend to work more collaboratively together.

There might be two separate types of providers, one delivering the main healthcare and one delivering mental health, for example, actually joining up resources to maximise their impact in seeing prisoners. As we all see and hear in the papers and on the news, prisoners are locked up sometimes for 23 hours a day, so they only have limited time to get to see that prisoner. Quite often the healthcare providers have to join forces to be able to see the prisoner at the same time. They are trying to work as creatively as they can within a very difficult environment at the moment.

Q6 **Diana Johnson:** Going back to the quality issue, you said that prisoners might feel that they are not able to access a GP as quickly as they would if they were in the community, but when they see the GP or the nurse, do they feel the quality of the healthcare that they get is good, or not as good as they would get in the community?

***Sean Cox:*** We get a very mixed response on that. It is very much down to the individual practitioners. I can give a couple of examples. When we were in HMP Send the other day, they were very much dissatisfied with the GP there. He literally just came in and was rushed because he could not get through the gate, so obviously his appointments were rushed. They did not feel that the quality of service was there, because the GP was under pressure himself to get everything done before prisoners were locked up again.

We get some conflicts with our service users and nurses, where they feel their attitude towards them is a bit unfair and a bit unjustified at times, but fundamentally, overall, they feel it is a fairly good service. There is always the debate about whether it is fair to say that healthcare in prison should be comparable to what is offered in the community. With all the restraints in a prison setting, is that a fair statement? Is it fair to expect that? I guess the jury is out on that one at the moment.

Q7 **Chair:** There are a lot of questions, and a lot of people want to come in, so we need short questions and answers if possible. Do either of you want to follow up on that answer?

***Stuart Ware:*** I would like to respond. Overall, to keep it in context, when I came out of prison in 1997, prison healthcare was terrible. Now it is a national health service-delivered contract, and there has been a vast improvement overall, so let's keep it in context. Strategically, it is a fantastic service—having that input in the prisons. The culture has changed. In other words, the NHS regards an older person as a patient—an older person with convictions, an older person with user experience—not as an offender or an ex-offender, so the terminology, the culture, has influenced the way that health is delivered.

There are examples of good practice. My colleague mentioned Send. I was going to say that Send is an example of good practice, because I have started doing some work with them. Send is a women's prison. Compared with other prisons, they have a fantastic through-the-gate system, with good social care linked with healthcare. Older women and other women released usually go to London, and there are good links. That is an example of good practice. But there are some terrible ones I could tell you about, where there is just no connection.

One issue of concern is that there may be good health assessment and social care in a particular prison, but when they are released and go to another area, there may not be the same support. Social care would not necessarily pick it up.

Q8 **Chair:** Hazel, do you want to add anything to what has been said?

***Hazel Alcraft:*** What we hear mostly from our members are concerns around access. I do not have as much information about the quality, but one piece of feedback we have had, particularly through an organisation called Birth Companions, which works with pregnant women and new mothers in Peterborough and Bronzefield as well as in the community, is that some maternity services can be very variable in quality. Picking up on Stuart's point about the culture, when there are midwives coming into the prison who are employed and working in the community for the NHS, there tends to be a much better quality of service and attitude coming through from them, whereas sometimes, when healthcare staff are employed and based full-time in the prison, there can be a tendency to absorb more of the prison culture, and that can have an impact on the quality of service.

Q9 **Rosie Cooper:** You have described healthcare in prisons as variable. To get to the core of the problem, do you think the CQC should be enabled to visit unannounced instead of what they are now required to do, which is co-ordinate with the prisons? Should the CQC be able to see healthcare delivered at source unannounced, as everywhere else?

***Sean Cox:*** I come from both sides, so obviously from User Voice's perspective, absolutely, I would say totally. It gives you a truer reflective representation of what is going on in a prison at any given time. As with any types of audit or inspection, the amount of prep work you have

leading up to that allows you to address some fundamentals, so unannounced inspections, absolutely, I think would be—

Q10 **Rosie Cooper:** On their own.

***Sean Cox:*** On their own, absolutely. At the moment they are worked with HMIP, aren't they?

**Chair:** Thank you. We will be speaking with them later. That is great.

Q11 **Ruth Cadbury:** We visited an older prison that had had some instability a few months ago. One issue was that on specialist support for drug addiction, there had been a long interregnum with no proper contract. Is it common that you get a break in service for specialist health services that prisoners are likely to need at quite a high level?

***Sean Cox:*** Not as far as I am aware. My previous role was as a director for a charity that delivered substance abuse services, and we never came across that sort of break, so what you are describing must have been an odd occasion.

***Hazel Alcraft:*** I know of one example from one of our members who provided mental health additional support. For a stretch of time, they were not able to run groups in the prison where they were contracted, because there was no psychiatrist in post in the prison. That is another example, but I am afraid I could not tell you if it is a common issue.

***Stuart Ware:*** I am not aware of that, I am sorry.

Q12 **Bambos Charalambous:** I would like to ask what you think about the three objectives outlined in the national partnership agreement. What are your views on that?

***Stuart Ware:*** They are good. The three priority areas are very good, and we would support them. A concern is when I look at the previous NHS partnership agreement for 2016 to 2020 and it mentions peer support. From our point of view, I would like to see more about how the peer support would interact with those priority areas, but we think it is a good strategy.

I have an issue with strategies. They are great at a national, higher level, but when they are actually delivered in practice lower down by prison governors and by healthcare and so on, it is the implementation in practice that we need to follow. How would it be understood? How is that strategy going to be delivered? It is a good strategy, but from our point of view I would like to see how it will work out in the end.

Q13 **Bambos Charalambous:** You want to see it implemented on the ground. It is fine having the strategy up high, but the implementation is the key.

***Stuart Ware:*** Yes.

***Hazel Alcraft:*** We were somewhat disappointed that the new agreement came out without any consultation, without any opportunity for people with lived experience or the sector to feed into developing the strategy and the objectives. Like Stuart, we would support the objectives—they seem to be the right three areas—but we would like to see them probably stronger than they are.

The objective to reduce health inequalities could be an objective to achieve health outcomes for people in prison equivalent to those in the community. As Sean mentioned, there is a previously accepted principle that there should be an equivalent level of healthcare, but, given the additional needs or high complexity of needs that people in prison often have, perhaps the aspiration should be a better level of care in order to achieve equivalent outcomes.

The third objective talks about supporting access to and continuity of care. Again, it feels quite difficult to measure progress against and be held to account, whereas an objective to ensure continuity of care, or access to care, would be a stronger aspiration.

***Sean Cox:*** To add to what Hazel mentioned about getting people with more lived experience involved at an earlier stage, we pride ourselves on having consultations with the service users to find out what they fundamentally feel needs to change. When you deliver strategies like this, having service user involvement right at the core is vital.

The priorities are set right. My only concern from the service user perspective is that when reality kicks in, when the MOJ's priority is running the Prison Service on a daily basis and NHS England's priority is trying to make sure health equalities are addressed, and health and social care needs are in there, do they end up being in a bit of a rubbing situation because they have different priorities? That is the reality being delivered on a daily basis, due to competing priorities and conflict.

Q14 **Bambos Charalambous:** To pick up on something Hazel said, and I think you touched on, Sean, about prisoners and healthcare services, do you think that prisons should deliver care to prisoners that is equivalent to that for the general public? I think you were saying, Hazel, that it should be better for prisoners because of their needs. Is that right?

***Hazel Alcraft:*** Yes. Given the health inequalities that people in prison face, they may need better healthcare services to achieve equivalent health outcomes, which is what I think they deserve.

Q15 **Bambos Charalambous:** Taking that further, what do you think the Government should do to improve the healthcare of people in prison in England? What should the Government be doing to improve it?

***Hazel Alcraft:*** Given the current context and the challenges of the prison environment, it would probably take quite a significant increase in investment and resource to achieve that. Otherwise, perhaps there is an opportunity for the new cross-departmental ministerial group on reducing

reoffending to look more broadly at how you can take a public health approach to crime and offending, and look at pooling budgets and redesigning some of the systems and services around individuals, much like some of the aspirations in the women's strategy, which was published last week. We would certainly support a lot of those aspirations, but I think they could be applied more widely.

***Sean Cox:*** For the group I represent, from the service user point of view, it would be to have more services such as User Voice consistently up and down the country. It is fair to say that where we are able to deliver our services at the moment, we are able to make some positive impact on services. We are teaching those guys and ladies to become responsible people, within their own healthcare needs; we are asking them to come up with suggestions about how they think healthcare could be improved in their local establishment and empowering them to make some changes. Having that consistent up and down the country, and building rapport with the healthcare providers and the prisons, would work. Obviously, we know about the need to probably have more financial investment.

To go back to the conversation about whether the healthcare should be comparable with the community, as I stated, pretty much 100% of the community in any given prison needs healthcare. When you compare that with a community outside, your local little village or your borough of London, very rarely do 100% of that community have reliance on healthcare, so it is about recognising the fact that the clients we are working with have high healthcare needs.

***Stuart Ware:*** An example of good practice is Public Health England's health and social care assessment, which was published in December last year, I think. It is guidance to governors and healthcare about how care assessments should be done, from coming into prison, through the prison system and out, so that even when they are transferred the assessment should be done.

Most prisons are trying to do the best they can, but it is to do with contracts and commissioning. You could take a look at that and have a closer look at the commissioning and contracts to deliver care assessments. That would then lock in access to GPs and so on. I would look at the strategy being delivered via the care assessments. That would lock in the services and strengthen them, but it is a matter of resources at the end of the day. There are some examples of good practice.

Q16 **Bambos Charalambous:** What could the Government and other public bodies do to support the voluntary sector to improve care for prisoners? I think Sean touched on that in his answer.

***Sean Cox:*** One more thing to add to what Stuart was saying is about the infrastructure of how we share information. Service users always criticise how many times they get assessed by different people. You get assessed by the healthcare provider, you get assessed by the prison and you get

assessed by the community agency. Somehow we ought to find a way of breaking the deadlock of all the data protection and have one healthcare system that moves from prison to community, so that offenders are only ever getting the questions once. If you ask a service user how many times they get asked their name or date of birth within a very short period, it is 10 or 15 times. Why, in this modern age, are we not relying on IT? I get that there is loads of data protection around that, but actually having one infrastructure that will share medical records across the board would be good.

Q17 **Bambos Charalambous:** Their medical records should follow them wherever they go.

***Sean Cox:*** Yes, and they do at the moment within the prison setting. They have a healthcare system within the prison, so it follows them. If they move from prison A to prison B it will follow them; it is all electronic, obviously. When they go back out to the community, it is normally done in a very old-fashioned way with a discharge letter sent off to their GP. If those two systems were actually able to align, it would eliminate a lot of risk to people's health on release.

***Stuart Ware:*** SystmOne, which operates for healthcare within the prison, is good. Until fairly recently, it didn't have any communication with healthcare outside, but I understand that prison healthcare are trying to do that. They are trying to have an IT system that will actually communicate with the outside GP, the healthcare, and so on, so I know they are working on that. It still needs tweaking. It is not perfect, but the system is there. The problem is that the security of C-NOMIS, within the prison estate, sometimes restricts more open access by the NHS, but I know they are working on it. I would like to see it driven through more.

***Hazel Alcraft:*** To pick up on the question about how to support the voluntary sector, the voluntary sector has a huge amount to offer in terms of supporting health and wellbeing in different ways, but in order to maximise that role it needs to be fully engaged and seen as an equal partner in delivering services in a prison setting.

Just as one example, in the last couple of years Clinks has supported a pilot project in three prisons in the south-west, engaging a voluntary sector co-ordinator, employing somebody from the voluntary sector embedded in the prison to co-ordinate what different services are doing in the prison. That has had some fantastic impact in terms of things like being able to sequence different services, seeing somebody on reception into prison and co-ordinating with the CRC and all the other different services, so that, when somebody is coming in on a short sentence or for a short length of time, they are able to start seeing people and get access to the interventions they need in a short time.

They have also been doing things like developing a directory of voluntary sector organisations and services working in prison, which might sound quite basic, but if you work in a prison you will probably be aware that it

can be very difficult to know who is coming in and out and what is going on in there. One of the things they have done in one, or possibly two, of the prisons is put a copy of the directory into the folders for people on the assessment, care in custody and teamwork framework, which is for people at risk of suicide or self-harm. That means that staff supporting a person, or that individual, have quick access to see what support is available: "What can I refer this person to or what can I encourage them to get involved in?" For a really small investment, that has been able to help the voluntary sector deliver the best they can to support prison health and wellbeing.

Q18 **Bambos Charalambous:** This is a final question from me. Next week, we have the National Partnership Board coming to give evidence at our joint session. What questions would you like us to put to them?

***Hazel Alcraft:*** We would love to know how they are planning to measure and evaluate progress against the national partnership agreement, and what their plans are for consulting on it, involving the voluntary sector and people such as User Voice, and hearing the views of lived experience in implementing it.

One issue we have not really picked up on yet is the needs of people from BAME groups in prison. We know that there is significant disproportionality in the number of BAME individuals in the criminal justice system, and there is interplay with health inequalities. For example, in some languages there is no term for depression, so how do you provide a mental health service for somebody? BAME people are under-represented in lots of prison mental health case loads, despite being over-represented in the population.

We would like to see more research and more detail in capturing the data and understanding what is going on, but it seems that the priority is the national partnership agreement. It is quite a high-level document, but it includes a couple of references to support for people with protected characteristics. We would like to know what they are specifically planning to do to address the needs of people from BAME groups, and maybe how it links with the work of groups such as the MOJ race and ethnicity board.

***Sean Cox:*** Mine would be a bit simpler than that. It would be just getting the service user at the forefront, to get them engaging more with strategic decisions. For us as User Voice, it would be to have consistent messaging across all estates. We are able to deliver certain councils in certain prisons, so it would be to have a framework where it is a mandatory requirement that you have user voices' views in all areas of healthcare and the prison setting rather than just in small pockets of it. Ideally, we would love that to be led by us. There are other provincial providers that could do it, but I do not think they could do it as well as us because we are so service-user led.

***Stuart Ware:*** The way I would like to see it is that we develop. Out in the community, there are personal pathways in the NHS, and local

authorities have "My own care plan" and so on. We are going to offer every older person in prison their own personal care plan for when they are coming up to release, because that is where the problem comes. It is a personal care plan, adapting what is already available in the community and personalising it in the criminal justice system. I would like to see how, bottom-up from the ground, people with multiple care needs can interact with the strategy and feed back to the ones leading the actual implementation of it whether it is working or not.

We have older veterans. They are often neglected by veterans agencies, because many older veterans are a little ashamed that they have ended up in prison and they keep quiet. Many of them are not tapping into the services, so we are signposting them. Older LGBT people are another group who are vulnerable and have specific needs, with signposting through our care plan.

I have to flag up older women who go in and out of prison. I am so pleased with the latest comment from the Ministry of Justice about the women's estate. With some exceptions, most older women, and women across the board, should not be in prison; they should have a community sentence. There are some who should be in a secure environment. Focusing on specific care needs, I would like to see fewer women going to prison.

**Chair:** Thank you for that.

Q19 **Luciana Berger:** I want to come back to some of the risks to the health of people in prison. We had the opportunity to visit a number of prisons last week. One issue I asked about and on which I was not able to get an answer, so it would be really helpful to hear from you on behalf of your members, is to do with sexual health and sexual assault in prisons, particularly the health implications of sexual assaults. When I raised this, I met blank faces. Can we hear what your assessment is and whether it is something that we should be concerned about?

***Sean Cox:*** From our representations, we are finding out that the male population are more open to admitting that they have been sexually assaulted in the past. It is about whether they have the right infrastructure to get the support they need once they have admitted that has happened to them in the past. As with females, there is a lot of shame, guilt and remorse around it. We would question whether the right infrastructure and support is there from the healthcare provider, whether psychiatry or trauma services, for the males. We have spent a lot of time developing trauma treatment for the female population, but do we need to focus a little bit more on the male population? There are a few coming through identifying as having been sexually assaulted in the past, and we want to do something about that.

Q20 **Luciana Berger:** What about sexual assault that happens in prison itself?

***Sean Cox:*** Not many of our service users have made comments on that, but we are aware that it happens. We do not have anything to bring to the table that can give you the answer you are probably looking for from our perspective, I am afraid.

***Stuart Ware:*** I can give you some examples if you like. We need to look at vulnerable adult legislation in prisons because there are some older people who have severe disabilities and care needs, and there are some prisons where they do not have proper care support. There are other prisons where they have peer carers who have been trained, and they can support an older person who may not be able to care for himself or herself in their cell. That does not take account of the personal care needs that they may have, which no other prisoner should deliver, but I know they do. I have instances of an older person being abused in prison. They are very vulnerable in some prisons from younger ones, and they do not say anything—they are afraid to say anything—but we pick that up from them. For older, vulnerable people with disabilities who are being abused, I would like to see the legislation enacted more within prisons. It does go on.

Q21 **Dr Williams:** Do prisoners trust that if they disclose something sensitive to health workers that information will be protected?

***Sean Cox:*** From our service user perspective, it depends what the information is. If it was around their own health need—maybe they divulged that they have hepatitis C, for example—they would have total trust in the healthcare professional that it would remain within that forum. If they were to disclose that perhaps they were using drugs on the wings, the healthcare professional would likely have to say to them, "I am going to have to disclose that to the wider audience because of risk of security, and so on," remembering the parameters we work in.

Sometimes it is, "I want to be open and honest with you as a professional, but at the same time I'm a bit wary about what the consequences may be," so they tend to withhold that information, but from what we have picked up from different prisons, it is very inconsistent. It really depends on what rapport individual service users have with the professionals. They learn to trust what they feel they can and cannot say. It is very inconsistent. There is always that bottom line of risk: "If I'm too open and transparent, even though I am really asking you for help, that may then come back and I may be punished for being open and honest, but really all I'm doing is asking for help with my drug addiction while I'm in custody." They could find themselves being punished for being honest.

***Stuart Ware:*** Trust is a very difficult one in prisons. We have many instances where individual officers are trusted. If a prisoner gets to know their officer on the wing, or there is a particular GP they trust, or someone in healthcare, they get to know that individual and they will trust them and open up, but they are very wary about revealing too much unless they can get some treatment for it. If it involves treatment,

they may well do it; they will do it. Again, that is where peer support can come in, because if you have done time, they listen to you, so that is where it comes in. It is about how you can bring peer support into that infrastructure, where sometimes we can counsel the person and say, "Let us see what we can do to break down that lack of trust." Overall there is and always has been a lack of trust in the prison system, because that is the way the system works.

***Hazel Alcraft:*** Our research would certainly echo that. We did some research a couple of years ago looking at valuing volunteers in prison that brought out quite strongly that people valued having volunteers or peer supporters. In particular, there is a level of trust because they are independent from the system, whereas a prison healthcare worker is still seen as part of the system.

Picking up on the point about disclosing substance misuse, we have seen a succession of Secretaries of State and Prisons Ministers who have been very focused on dealing with substances in prison by cutting down on supply and dealing with that with punitive approaches, rather than looking at reducing the demand and supporting treatment. Both of those are there, but there has been a real focus on the supply and the punitive sanctions, and that makes it very difficult for somebody to speak up and say that they are having an issue with using NPS or something like that within the prison, if they know they are going to lose their privileges. That is a particular issue.

Q22 **Andrew Selous:** Is your experience that it is easy to get access to prisoners—to get in and out of prisons? With staff shortages in a number of establishments, do you find it difficult to get in? I do not know what it is like trying to be issued with a set of keys or what your experience has been.

***Sean Cox:*** From an organisation point of view, we employ 90% ex-service users, and when going through the vetting process they quite often come back as not acceptable. They have an offending behaviour background, so they are deemed too big a risk to put into a custodial setting. We have the vetting-plus process where we can appeal that, and we try to do a risk assessment on our staff to be able to get them access to keys.

I have been around for quite a while and the system has got better, so we are able to get some ex-service users back into the prison and held to account for a set of keys, which for them is a big achievement. I remember when I was in custody, and 10 years later, when I started working in a prison and was given a set of keys, it was quite a reward in a way. Whereas before when I was in custody I had to be locked up like everyone else, now I am mobile and I can go round the prison. That is quite nice.

When it comes to the fundamentals, once you get past that process, we have the restrictions of the prison regime. They may be on lockdown

because of lack of officers, so we are not able to access prisoners or carry out our activity. We have become accustomed to that over the years. We accept that is the nature of the beast, so we have modelled our council service to be adaptable, so that we can still engage with service users, because, fundamentally, that is what we are about. If we cannot engage with those service users, we do not have a service to offer, they are not going to get their voice heard and we are not going to be able to influence change. We find ways around it. It is frustrating, but it is not going to change overnight, so we tend to work with that frustration rather than moaning about it.

***Stuart Ware:*** The reality is that prisons are secure. You need a secure environment, so security is a priority. You have to work within that setting. Healthcare has to work within that setting, and that makes it different from the community, so there are controls. I am security-cleared and I have keys to some prisons. I cannot have keys to all the prisons, otherwise I would be getting in a muddle. Things are very good and there is no problem with security. It comes back to another way of trust; they trust me as an ex-offender, not that I like that term, to have the keys, and I respect that trust and pay back that trust so that they can trust me, and others who follow me can have that trust as well.

The reality is that the prison is a secure environment. I remember when I was in that there were some dangerous characters. Some prisoners had to protect me because there were dangerous characters. We have to respect security within prisons and that is the environment one has to work with.

***Hazel Alcraft:*** I agree with that, but our members report increasing difficulties in recent years with being able to access people in prison, particularly perhaps, say, an arts group going in to run courses with people. If there are not enough staff to unlock the prisoners and bring them to the group, sometimes activities have to be cancelled, which then has a knock-on effect because people are left longer in their cell, not able to access purposeful activity, and that can lead to increased boredom and frustration, and have an impact on the prison environment.

One recent example is an organisation that had staff who were drawing keys and then, when the prison recruited more staff, they did not have enough keys for their prison staff, so the keys were taken away from the voluntary sector service. Having more staff still did not mean they were able to access them. It is an issue.

Q23 **Ruth Cadbury:** You were generally fairly positive, I think, when you mentioned the "Women in the criminal justice system" report. Is there anything you particularly want us to focus on in looking at the new policy and how it is rolled out?

***Hazel Alcraft:*** For us, the major concern is that it is a very good aspirational strategy but there is lack of detail on timings. We are very concerned that the financial requirements for delivering good-quality

services to women in the community are not there. We did some preliminary estimates with the Prison Reform Trust that suggested it would take around £70 million to provide good-quality, holistic services to all the women currently under supervision in the community. There is nothing like that amount of money against the strategy at the moment. That would be our key concern.

***Sean Cox:*** From the service users' point of view, we know that the female estate is a lot smaller than the male estate. There are not so many female prisons up and down the country, so their biggest criticism has always been about being so far away from their home. I reiterate that message. The strategy tries to address that, but I would really push that home, to try to keep family ties going, just as in the male estate. Being nearer home while serving a custodial prison sentence would be a big step forward for them, whether that means building more and smaller female prisons or taking on other ways of sentencing. Fundamentally, they want to be a bit nearer their loved ones and their home.

***Stuart Ware:*** I would add consistency across the estate, so that we can move from one women's prison delivering a good service to another one delivering the same service. The strategy should apply in implementation to all prisoners, whether male or female: consistency right across the board.

**Chair:** Thank you. On behalf of both Committees, thank you for everything that you and your volunteers are doing across the prison service, which is really valued, and thank you for your evidence this afternoon.

## Examination of witnesses

Witnesses: Rebecca Roberts and Elizabeth Moody.

Q24 **Chair:** Good afternoon and welcome to our second panel. For those who are following from outside the room, could you introduce yourselves and who you are representing today?

***Elizabeth Moody:*** Thank you very much for inviting me. I am Elizabeth Moody. I am the acting prison and probation ombudsman. The PPO investigates complaints from prisoners and various other groups in detention. It also investigates the deaths of prisoners and various other groups in detention. Our remit, in terms of complaints, does not include complaints about the clinical judgment of healthcare professionals, so most of what I have to say is drawn from our experience of investigating deaths rather than complaints.

The other general thing is that, because we are investigating deaths, we are investigating cases primarily where something went wrong. I can talk

quite a lot about cases where things have gone wrong, but I have less to say about good practice, although we obviously see some examples of it.

**Chair:** That is very helpful. Thank you, Elizabeth.

***Rebecca Roberts:*** Good afternoon. I am Rebecca Roberts and I am head of policy at the charity INQUEST. We are an independent charity. We provide expertise on deaths in state care and custody, with a particular focus on prisons, police, immigration detention and anywhere state or corporate accountability is called into question. We work alongside families, provide advice to them and ensure that they get expert legal advice.

We have a team of five caseworkers. They are working on the 800 cases we have open at the moment, and 300 of those relate to prison deaths. We find that families want truth, accountability and justice, but most importantly they want to make sure that the same thing will not happen to another family. We campaign alongside them to bring about change.

We have been working in this area for almost 40 years. Because of the breadth of it, we see the same systemic issues coming up time and again, and the failure of state agencies to learn from mistakes. In the evidence we submitted, we focus primarily on self-inflicted deaths, but we have growing concerns about non-self-inflicted deaths and deaths happening to people after they leave custody.

**Chair:** Thank you very much.

Q25 **Andrew Selous:** From your recent experience, what are the key issues affecting the health, safety and wellbeing of prisoners in England at the moment?

***Elizabeth Moody:*** As you know, in the last few years there was a serious increase in the number of self-inflicted deaths, and I can talk about some of the reasons for that if you would like. The number of self-inflicted deaths went down in the last financial year. However, it was starting to climb again in the second half of the financial year, so we have a number of concerns.

It would not be correct to say that the problem has been solved, not least because rates of self-harm and violence in prisons are at a very high level. That is one concern. Mental health problems for prisoners are another concern. We are seeing people being sent to prison inappropriately and waiting a very long time for transfers to hospital.

Q26 **Andrew Selous:** You said sent to prison inappropriately. Could you expand on that?

***Elizabeth Moody:*** We see cases of people who are clearly mentally unwell but who have not been diverted before they get to prison, and, on arrival or within a very few days, it is very apparent that they have

serious mental health problems, which sometimes lead to suicide if they are not dealt with properly.

Q27 **Andrew Selous:** Have you seen anything in the recent policy announcements on mental health from NHS England that gives you hope that that issue will be addressed shortly?

***Elizabeth Moody:*** Over the years, I have seen a lot of announcements.

Q28 **Andrew Selous:** We have had rather more recently, with a bit of money pledged in the last couple of weeks.

***Elizabeth Moody:*** Certainly. As people were saying in the last session, it sounds very promising. We will have to wait to see what actually happens.

***Rebecca Roberts:*** The challenge that we are seeing in prison, to pick up the point Elizabeth made about deaths in custody, is that we saw a huge spike in 2016. Overall, the numbers of deaths is still at historically high levels. I think 2017 was the second highest year on record. In particular, self-inflicted deaths have dropped, but we cannot be complacent because they are still very high, and natural cause deaths, as defined by the MOJ, have not come down anywhere near as far, so we have—

Q29 **Andrew Selous:** I am sorry to interrupt. Do you think there is a reason why there was a fall? I take your point that it is still high, but can you deduce what that is attributable to?

***Rebecca Roberts:*** I suspect there are complex reasons. Following the deaths, there was growing concern in the system, so more effort was put in to try to make sure that support was available to prisoners.

Q30 **Andrew Selous:** Can you be specific? Were there particular things the Prison Service did that helped?

***Rebecca Roberts:*** In terms of our learning, the cases we deal with are where deaths have happened, so there has been a sharper focus. We have seen reports from the Independent Advisory Panel on Deaths in Custody. There has been more concern about it, but, as Elizabeth was saying, we see people coming into prison with serious mental health problems who should have been picked up in the community.

People are being placed in very unhealthy, unsanitary environments as well; we have had a number of urgent notifications from the chief inspector this year already. In the case of Nottingham, concerns were raised about how the poor conditions in Nottingham were causing people to take their own lives. We see ongoing issues. In terms of distress and self-harm in custody, each day there are 120 instances of self-harm, and that raises questions about healthcare, but it also shows rising levels of stress on the system.

Q31 **Dr Cameron:** I want to ask about access to psychiatric assessment for those who come into prison or who develop an illness in prison and are

unwell. Is there timeous access to psychiatric assessment, or is there a shortage of access to psychiatry that could be addressed?

***Elizabeth Moody:*** As with almost everything, I am going to start by saying that it is very variable. We see some excellent practice where people come in and are assessed very early on. We see other cases where we are told by healthcare staff that urgent referrals should be dealt with within five days, but three or four weeks later people are still waiting for an assessment.

There is a particular problem for people who have what you might call one of the more niche conditions, people with personality disorder, autism, learning disability or brain injuries, and for people who have lower-level psychiatric conditions, such as depression and anxiety. If you have a florid psychotic presentation, your chances of being seen quickly are much better, although not always.

***Rebecca Roberts:*** In some of the cases on which we have been supporting families, we see mental ill health treated as a discipline problem rather than it being recognised that people are exhibiting extreme symptoms of distress and mental ill health. We are not seeing the correct approach. There are also issues with transfers to prison and medication not being made available in a timely manner, which adds to people's levels of distress.

Q32 **Rosie Cooper:** I have quite a short question. Healthcare is delivered in prisons by health organisations, usually contracted, and there will be specific levels and timescales for prisoners to be seen by a psychiatrist or a doctor on admission and whenever an episode arises. When you know that those contract levels are not being met, as you have just described, what can you do to help? What happens?

***Elizabeth Moody:*** We can make recommendations to the healthcare provider and, if necessary, to NHS England to address the issue, but a lot of it is down to staff shortages, with lots of agency staff, and in some prisons shortage of healthcare staff and shortage of prison staff. The shortage of healthcare staff is a really serious problem.

**Rosie Cooper:** Absolutely, and if you are in prison you cannot do anything about it; you have no choice of provider, so the responsibility lies with those who are to provide it and your good selves.

***Elizabeth Moody:*** Yes.

Q33 **Rosie Cooper:** What can you do to ensure that the service is delivered? How can you make accountable people who ought to be held accountable? The board at Liverpool community trust, for example, got many of your reports and ignored them. What can you do?

***Elizabeth Moody:*** We can draw attention to the problem. Ultimately, I cannot make anything happen; I cannot make people follow the

recommendations. We can draw attention to it. Where we are making repeat recommendations, we escalate the problem.

Q34 **Victoria Prentis:** The suicide rates are now very much higher than in the general population, for men nine times higher for prisoners and for women 15 times higher than in the age-standardised general population. You have talked already about some of the reasons behind that, and you briefly mentioned systemic issues. Are you content with the system of assessment when people enter prison, and do you think further screening should be done, for example, for previous brain injuries or for childhood experiences, of parents having died by suicide, for example?

***Elizabeth Moody:*** We see examples of good assessment when people come in. There is no reason why those issues cannot be picked up, in theory, although in practice people often come in late at night when there are time pressures. They should be seen the following day, and that does not always happen. It can be very good, but it is often rushed or does not happen at all in some cases.

***Rebecca Roberts:*** That comes up in our work. We see failure to conduct medical assessments as people are coming in, and in transferring information from the police to the courts and to prisons. There is a lack of communication with families, who can often see that somebody is unwell and does not have access to their medication, and the treatment of long-term chronic health conditions is not picked up as people are coming into prison. In some of the case studies we have provided, young people are dying related to asthma and things like that. They are things that should be treatable, and medication should be made available, but they are just not being picked up.

Q35 **Victoria Prentis:** Is it still the case that most of the suicide deaths occur very early in the prison sentence?

***Elizabeth Moody:*** It is a particularly dangerous period for suicide. We see suicides all the way through people's sentences, including people who are just about to be released, but the early days are very much a risk area where staff need to pay attention.

Q36 **Victoria Prentis:** Is there evidence for that?

***Elizabeth Moody:*** Yes.

***Rebecca Roberts:*** Something else we mentioned in our written submission is that there is also a risk when people are leaving prison. We are seeing high rates of self-inflicted deaths there. Through-the-gate support is needed, both for healthcare and mental health, maintaining access to medication, and having the right links for housing and community support once people leave prison. Leaving prison can often be quite a traumatic time, having to get back to your life as it was before, and things being very different and being distressed.

Q37 **Victoria Prentis:** We are seeing the partnership board next week. Do

you have any recommendations that we ought to be passing on to them?

***Elizabeth Moody:*** As was said in the previous session, the priorities are sensible. They are difficult to disagree with. It will be about implementation. The areas we are most concerned about are mental health, the need for a strategy for older prisoners and the really serious problem of drugs in prisons, particularly psychoactive substances. There is a really urgent need for action on that.

***Rebecca Roberts:*** Healthcare in prison is one area that is often overlooked. We focus a lot on the practices of prison staff within the prison institution. There needs to be much better oversight and accountability of healthcare providers within prison, both private and NHS.

Something that comes up frequently in our work is that recommendations are made, whether through the PPO or the chief inspector, and we see coroners making recommendations to prevent future deaths, and nobody is overseeing all of those recommendations, so we do not see what follow-up happens. You might see short-term changes in the immediate aftermath, but then we do not see long-term sustainable change. For a number of years, we have been calling for a national oversight body that would be responsible for monitoring, collating and assessing those sorts of recommendations, to make sure that future deaths are prevented.

Q38 **Victoria Prentis:** The other recommendation that INQUEST has made repeatedly is for improvements in investigations post death. Would those remain your two big asks?

***Rebecca Roberts:*** Yes. In terms of practical, immediate things we can do now, we have raised clinical reviews, and their independence and thoroughness following a death, but there are bigger questions about why many people are in prison who should not be there in the first place. That is a broader public health issue of mental health and healthcare for people before they even hit the criminal justice system.

***Elizabeth Moody:*** We do not have the expertise or the resources to conduct clinical reviews ourselves when we are investigating deaths, but we have worked very closely in the last few years with NHS England to improve the quality of clinical reviews.

Another really important point is that we do not just take what we are given by a clinical review. Our investigators are expected to challenge it, obviously from a lay person's point of view, and we do. With one or two clinical reviewers, we have said to NHS England, "We do not want to use this person again." It is something we have worked hard on because we recognised that there were some issues, but it has got a great deal better.

Q39 **Luciana Berger:** We know from the figures we have that at least one in 10 of the prisoners who died by suicide between 2012 and 2014 were waiting for transfer to a mental health facility. Those figures date back to

2014, and I wondered how many of the cases you have investigated or are supporting are about people awaiting transfer to mental healthcare.

***Elizabeth Moody:*** I do not have the figures for recent years, but that feels too high to me. We see some very distressing cases where people are waiting for a transfer and have waited far too long for various reasons, but I would not have said it was one in 10. I will find out and write to the Committee.

***Rebecca Roberts:*** I do not have the figures on that, but there is also a consideration about the availability of mental health support for people while they are in prison, before transfers. We see failures to adhere to the ACCT process, lack of training for that and inability to follow simple procedures, which comes down to staff training, and, as I mentioned earlier, mental ill health being treated as a discipline issue rather than being taken seriously in terms of risk to life.

***Elizabeth Moody:*** I support the last point. We see some very distressing cases where mental ill health has been misinterpreted as a discipline issue, and therefore not treated, and people are not getting the support they need.

Q40 **Chair:** Thank you. Before asking a question on mental health, I state for the record that my husband is an NHS forensic psychiatrist.

In the past, this Committee has looked at suicide prevention. Could you set out for us why the term "self-inflicted death" is used rather than "suicide" and whether that gets in the way, or do you support continuing to use that term?

***Elizabeth Moody:*** It is a technical thing; not every self-inflicted death is an intentional suicide.

Q41 **Chair:** But the same issue occurs outside. Would you like to keep the term "self-inflicted death", or do you feel that brings a pejorative element to the way we talk about this?

***Elizabeth Moody:*** I have not found that to be a problem. To be honest, we are not very interested in the label when we are looking at a death. We are more interested in the circumstances that led to the particular death, whether self-inflicted or natural causes. I do not think the labels inhibit us.

Q42 **Chair:** It does not get in the way of what you are trying to do. How about you, Rebecca?

***Rebecca Roberts:*** We tend to refer to self-inflicted and non-self-inflicted. As Elizabeth said, within the category of non-self-inflicted, some may be found to be accidents; the coroner will conclude that they were accidental. From the perspective of the families, I guess it is also about thinking about the broader context and the situation within which people find themselves in extreme distress.

We tend to talk about non-self-inflicted because that covers a broad range. The issue around natural causes implies that deaths are natural and inevitable, when we find that they are often preventable.

Q43 **Chair:** My next question was going to be about when you use the term natural causes. It seems that you have either self-inflicted or natural causes. Would you prefer that there was a change to natural cause deaths?

***Rebecca Roberts:*** Natural cause deaths in prison are far from natural. In the cases that we come across, people are dying very young. Often the word that comes up in jury conclusions is "neglect." Healthcare is often seen to be a key issue. We are talking about early, avoidable deaths. As I mentioned earlier, self-inflicted deaths rose by 36% in 2016. Natural cause deaths came up to 39%, and we saw a drop in self-inflicted deaths of 40% and only a 10% drop in natural cause deaths or non-self-inflicted. Often that is attributed to an ageing prison population, and I am sure that is part of it, but we did not suddenly see the jump up in 2016-17.

Q44 **Chair:** I think it would surprise many people following this inquiry that life expectancy is 56 for those who are in prison, so, when we talk about an elderly prison population, we are talking about people over 50, which, to somebody who is 56, does not feel terribly old. The way we refer to things can be very important in how seriously they are taken. If you refer to something as a natural cause death, there is a tendency to say that it is to be expected, whereas it is not to be expected that people die at 56, so should we change the term natural cause death?

***Rebecca Roberts:*** Yes. I would argue that it should be non-self-inflicted. Natural cause deaths and non-self-inflicted deaths are invisible in the public and political debate around prisons at the moment. There has quite rightly been a huge focus on self-inflicted deaths, but we are not looking at what is happening and directly thinking about the conditions that people are in, and the impact that is having on their health. We need to think about the healthcare provision that is available and provided to people in prison and the impact that is having. It is something we are keeping a close eye on.

We do not have all the answers. We need to know more about what is happening and what has happened in particular in the last few years, but also to think about this as a long-term problem. It is not just something particular to the last two or three years. Deaths in custody are a long-running issue and concern.

Q45 **Chair:** If we changed the term, would that allow us to look at more of the public health issues, because this is very long-term? Do you feel that some of the drivers for such low life expectancy are happening long before people reach prison? Would it allow us to have a greater focus on health inequalities?

***Elizabeth Moody:*** Yes. Prisoners often enter prison with an enormous array of health conditions. I absolutely understand what you are saying about the terminology. I do not think, in practice, that it affects the way we investigate deaths. Some of the deaths we investigate are of very elderly people with serious health conditions where the death is not preventable, but in others we do not shy away from saying that we think neglect was involved or that the death would have been preventable if the person had received better healthcare. But I understand the point you are making.

***Rebecca Roberts:*** It is worth remembering that people in prison are in a uniquely vulnerable position because they do not have access to the same level of care; they do not have control over their medical care. Thinking about this more broadly, we should try to focus people's minds and attention on non-self-inflicted deaths and the impact that prison conditions are having on people's wellbeing and health.

Q46 **Rosie Cooper:** Do you think a healthcare professional should be held accountable for a series of tests? For example, I am thinking of a case at Liverpool where a prisoner who died from lung cancer exhibited symptoms, would have been treatable and would have lived longer had that been addressed. Do you think the health professional should be held to account?

***Elizabeth Moody:*** I do. I will come back to that, if I may. We recommend, both with Prison Service staff and healthcare staff, that individuals should be held to account. The other point is that sometimes they are operating in a very difficult management structure, and that also needs to be taken into account.

Q47 **Rosie Cooper:** Absolutely; I understand that. Ultimately, it is with the state, the governor and backwards right to this place, where responsibility will finally end. I am not picking on the healthcare professional, but I wondered whether, if they had something at stake, they would strive harder to get the governor and others to listen to the need for tests or treatment of some sort.

***Elizabeth Moody:*** Yes. I did a case last week where we recommended that a nurse should be referred to the Nursing and Midwifery Council because of very poor practice, basically neglect of a prisoner, so absolutely. Yes.

Q48 **Rosie Cooper:** It nearly always seems to be nurses who get referred. We need to take heed of that as well.

***Elizabeth Moody:*** I would agree with that.

Q49 **Chair:** You mentioned in your opening comments that you are not able to comment directly on clinical practice. Would you like to have greater powers to be able to do that, or do you think it is about right that you should have the powers to refer to another body?

***Elizabeth Moody:*** We comment on clinical practice, in the sense that the clinical reviewer gives us a review of the healthcare that the individual has received and we incorporate that in our report. It was more that, in our remit, our complaints function does not include clinical factors.

**Chair:** Thank you for clarifying that.

Q50 **David Hanson:** Rebecca, you mentioned earlier the challenges of post-release deaths. The figures you have given us seem to indicate quite a high rise in post-release deaths compared with the rise in the population. Do you want to comment on the trends and any of the things you think we ought to learn from them?

***Rebecca Roberts:*** Between 2011 and 2017, we saw 1,300 deaths of people after they left prison. There has been a rise in self-inflicted deaths of 500% at a time when case loads doubled. Part of that might be down to better recording practices, but I do not think that is all of it. We have to ask questions about the role of transforming rehabilitation and the support people are receiving prior to and following prison. It is something that just does not seem to be on the radar of any of the key agencies. It is not something that the PPO currently investigates; it is not something that I see the chief inspector of probation mention in any of the annual reviews they produce. If your client group is not surviving a service, it raises serious concerns about the service's effectiveness.

Q51 **David Hanson:** Who do you see as responsible for the through-the-gate process, from prison governor and prison staff through to CRCs or probation generally? Where is that responsibility in terms of health?

***Rebecca Roberts:*** You should have offender managers working in the prison and supporting people prior to release. It is about support as people go out into the community, the amount of contact they might have, the support they have in terms of housing, and mental health support.

Q52 **David Hanson:** You have just suggested that there is a fundamental problem with the CRCs. Could you elaborate on that? Are there particular challenges that CRCs have brought to the table in relation to the increases?

***Rebecca Roberts:*** I am not an expert on probation and I cannot comment directly on that. It is something we have noticed as a watching brief. I came across a prevention of future death report from a coroner, which referred to the air of complacency within the Prison Service about people's safety as they left prison.

Q53 **David Hanson:** To what would you attribute the rise in the number of deaths outside prison, post supervision?

***Rebecca Roberts:*** I can speculate, but it needs to be better investigated. I would question the amount of support that people are receiving as they leave prison and go into the community, but we need to

know more. I do not have access to that information. I have a list of names of people who died in the first three months of 2017, but we know very little about them and the causes of their deaths.

Q54 **David Hanson:** Do you have any information on the period from release of prison to death that would be helpful to the Committee? People can still be on supervision, but there is a considerable period; it could be in the first 48 hours, the first week, the first month or the first three months.

***Rebecca Roberts:*** I believe some of that may be in the statistics produced by the Ministry of Justice. There is good academic research in this area, so I could provide those links to you afterwards, if it is helpful.

***Elizabeth Moody:*** People are particularly at risk in the couple of weeks after they have been released, and I could provide some statistics on that. We do not investigate deaths in the community, but we investigate deaths in approved premises. One of the things we are seeing there is more deaths from drug misuse, particularly PS misuse. It appears that the problem has now moved out of prisons into approved premises.

Q55 **David Hanson:** In terms of healthcare, what is your assessment of the liaison between the healthcare received in prison and the healthcare received by the individual wherever their final destination is post leaving prison? Very often, it may not be the same health trust or health board and there may be no relationship at all between the prison and the ultimate destination.

***Rebecca Roberts:*** That is a good question, but I can only speculate, because, as far as I am aware, those deaths are not regularly investigated.

***Elizabeth Moody:*** We are not investigating them. I would not have an issue about investigating them, but it would obviously require more resource.

Q56 **David Hanson:** I just want to pin it down. If a death occurs post supervision, what relationship is there between the CRC, probation and/or the prison that the individual has left prior to that supervision? Are there case conferences, are there discussions about why it happened and has someone taken responsibility? Does the offender manager follow it through? Are they held accountable?

***Rebecca Roberts:*** As far as I am aware, I do not know that that happens. There does not seem to be any formal policy around that, but those questions need to be asked of those responsible for probation services. The amount of scrutiny we have when there are deaths in prison could always be much better, but there seems to be a complete absence of any form of investigation and follow-up when something happens to somebody on post-custody supervision.

Q57 **Dr Cameron:** I want to ask about deaths following release from prison.

Is there any data on whether that is lifers who are perhaps finding it difficult to adjust post release, or short-term prisoners who are coming in and out of prison and perhaps have drug-related issues and are more likely to overdose?

***Elizabeth Moody:*** Because we do not investigate those, I cannot tell you the answer. There has been research. I know that there is a particular risk of overdosing shortly after release from prison. That is something we have some expertise on.

Q58 **Dr Cameron:** Do you think that more could be done on education for prisoners prior to release on those issues, or in some form of health follow-up very quickly after release that could make a difference?

***Elizabeth Moody:*** We recently published one of our "learning lessons" bulletins looking at what happens in approved premises, which is the only area I can really talk about, because that is where we investigate. We found that although staff are very dedicated—this is not a criticism of them as individuals—approved premises and the probation service were lagging behind prisons in the way they addressed psychoactive substances in particular. There was a need for more testing in approved premises, and a need for more staff awareness and discussions with residents about it. As I say, we produced a bulletin on it, which I draw to the Committee's attention.

Q59 **Dr Cameron:** That would be really helpful. Did you have anything to add, Rebecca?

***Rebecca Roberts:*** No. I can point you to and provide some more research in the area. The Equality and Human Rights Commission commissioned some research a few years ago on that, and there is ongoing work that is being published, so I could direct you to that.

**Dr Cameron:** Thank you. I want to put on record that I have previously undertaken mental health assessments in and out of prisons.

**Chair:** Thank you both for your evidence this afternoon.

## Examination of witnesses

Witnesses: Professor Steve Field, Jan Fooks-Bale, Peter Clarke and Paul Tarbuck.

Q60 **Chair:** Thank you to our final panel of the afternoon, and thanks to all of you who were sitting in on our previous sessions. It will be very helpful to those following from outside the room if you could introduce yourselves and who you are representing this afternoon.

***Professor Field:*** I am Professor Steve Field. I am chief inspector of general practice at the Care Quality Commission. The title is general practice, but health and justice, prisons and youth offender institutions are all part of my remit and my directorate. That is why I am here.

***Jan Fooks-Bale:*** I am Jan Fooks-Bale from the Care Quality Commission. I lead the health and justice inspection team. We conduct most of our inspections in partnership with other inspectorates such as HMI Prisons.

***Paul Tarbuck:*** I am Paul Tarbuck. I was the head of healthcare inspection at HMI Prisons until Saturday. I have just retired.

**Chair:** Congratulations. This is a great way to celebrate your retirement.

***Peter Clarke:*** I am Paul's heartless boss; I am Peter Clarke. I am the chief inspector of prisons. Our statutory remit is to inspect particularly the treatment and conditions of prisoners. We also inspect in immigration detention, police custody, military detention and various other contexts. Primarily, the core of our work is inspecting in prisons.

Q61 **Dr Williams:** Can you describe the current state of health and care in prisons in England?

***Peter Clarke:*** Perhaps it would help if Paul and I split this between us. I will give you what I think are some of the contextual issues that affect health and healthcare. Paul can then perhaps bring his more clinical expertise to bear.

The contextual elements are ones that, I am afraid, are all too frequent in our reports. The sorts of things that can contribute, in our view, to poor health and a lack of wellbeing include lack of time out of cell. We frequently report that far too many people are held in cells for far too long, which is obviously combined with lack of purposeful activity, because if they are locked in their cells for 20 or 22 hours a day they cannot get to education, training or any other type of activity.

It also plays into living conditions. We frequently report that far too many people are sharing cells that are overcrowded. We produced a thematic report last year pointing out that many thousands of prisoners share a tiny cell, which is not only their living room and their dining room, and to an extent their kitchen, but also their lavatory. We find that that cannot possibly contribute to a sense of wellbeing and so on.

In terms of mental health, around 40% of people presenting at prison say they are suffering from some form of mental health issue. Our sense is that there is a huge amount of undiagnosed need in prisons. The issue of illicit drugs has clearly contributed not only directly to ill health in terms of the impact of the drug on the person when they take it, but to the environment as well, with the violence, the fear, the debt and the bullying it places many people in. They self-segregate and self-isolate, and instances of self-harm and suicide tragically flow from that. There is also the impact on staff, of course—the secondary impact of exposure to some of those substances.

We also have the ageing population. I listened to part of the last panel, and the fact is that, for whatever reason, on best projections there will be

around 15,000 people over the age of 50 in prison by 2020. As we know, it is for a number of reasons, but the fact is that there are a lot of people who are going to be in prison in old age and needing specialist support. There is going to be a need for much more palliative care. The thing that disturbs me as chief inspector going around the country is that there seems to be a lack of joined-up strategy around that.

There are some pockets of good practice, but when I ask at prison A whether they are aware of what is being done at prison B to support their older prisoners, invariably the answer is no. The Ministry of Justice announced last year that they were going to create a strategy for older prisoners, and a steering group was set up. I was a member. It met once. A paper has now been produced, which, frankly, in my view, is not in any way strategic. It talks about more of the same. My view is that there needs to be a broader think about what needs to be done for a cohort of prisoners who, although they may need to remain in custody, do not necessarily need the same type of custody. There is good practice though, which needs to be picked up.

Finally, there is the suicide and self-harm element. In the vast majority of prisons, we make comment about what more needs to be done. In particular, we comment where the prison and probation ombudsman's recommendations have not been adequately addressed by prisons.

That is my broad take on the range of issues that impact in a negative way on the health and wellbeing of prisoners.

**Dr Williams:** Grim.

***Peter Clarke:*** I am afraid it is not a very optimistic picture. I can try to paint it some other way, but it is very difficult to do so when I see, with the regularity that I do, some really very difficult situations in prisons. I am not saying that prison staff are not on the whole trying to do their very best; they are. There are a lot of dedicated professionals, both in healthcare and in general prison staff, but they are facing some enormous challenges, not least staff shortages. I know that is being addressed now, but the shortage of staff for the past few years has meant that many prisoners have not been able to be got out of their cells. They have not been able to get to their medical appointments, whether in the prison or outside. There has been an inevitable knock-on effect on their health and wellbeing.

Q62 **Dr Williams:** Can anybody else add to that overview?

***Professor Field:*** Perhaps I could add something from an oversight point of view. Our responsibility in the Care Quality Commission is across England, whether you are in prison or out of prison. Many people are out and then go in, and then come out again. That interface is very important.

We are dealing with a population of some of the most vulnerable people in society. They are vulnerable before they go in, and all the way through

the system. We are dealing with a population that goes from 16 to 21 in the youth offender institutions and is then increasingly aged in the ageing estate. We are dealing with substance misuse, and mental health and physical conditions. As Sarah said earlier, people tend to die younger than in the rest of the community. It is only worse in the homeless population, but many people who have been in prison end up homeless, so that is a really big issue as well.

There is something about the people we are working with to try to improve their health. In some respects, we have a captive audience there—

**Dr Williams:** Literally.

***Professor Field:*** We should be able to do more than outside. We monitor the quality of care in the 113 prisons and youth offender institutions, in partnership. The partnership works well with HMIP, but we do it under a different set of regulations.

We have not yet completed the baseline. Since 2015, we have been going together into prisons. We have been to about 80% of the prisons. We follow the HMIP inspection regime, but we go earlier if we get concerns; and, if they get concerns about health, we go in earlier. We found that almost 50% of that 80% are not meeting all the fundamental standards.

If you want a more academic angle on things, there are fundamental standards we look at for the providers of care. The providers of care often are NHS providers, providing care to patients in the community, or they could be private providers. We look at them alongside what we would do in the outside world. We do not rate prisons, but we look at the fundamental standards, so it is a concern to us that there is so much variation and that some prisons get worse while some improve. Because we do not have the baseline, we cannot give you what you want, which is the complete picture at the moment.

Q63 **Dr Williams:** Should the health of prisoners generally improve during their time in prison?

***Professor Field:*** It would be a generalisation to agree and say yes, because some people do not improve in the outside world, as well as in the inside world.

Q64 **Dr Williams:** As an ambition, would you want to see people's health improve? You have described a captive audience of unhealthy people. Do you see prison as an opportunity to improve their health?

***Professor Field:*** It is a great opportunity to improve, but in circumstances that are very difficult. As Peter rightly said, prisons are under pressure from the estate and from staffing. In an ideal world, if we had the right number of people looking after those vulnerable people from a health and social care point of view—don't forget the increasing social care needs in prisons—there are all sorts of interventions we could

do when people are in there that we cannot do in the outside world. It is an opportunity we should grasp.

Q65 **Dr Williams:** Is that opportunity being grasped at the moment?

***Paul Tarbuck:*** Could I come in on an earlier point that you raised? In my opinion, it is undoubtedly true that the standard of healthcare in prisons has improved over the last 10 to 15 years. Public Health England has done some work on that and demonstrated that, because of the introduction of NHS commissioning of services in prisons, what you would now see in a prison should be broadly similar to what you would see in the community, bearing in mind the context in terms of the service, its quality and the mix of professionals available. Then, of course, there are all the issues about gaps in service that colleagues have just mentioned. Of course, they are not ideal, but health services in the community are not ideal, so you have to put it into context.

Q66 **Dr Williams:** I understood from what Steve just said that 50% of the providers you have currently assessed are not meeting the fundamental standards. That is not the case in the community. There are some providers in the community not meeting fundamental standards, but it is not as much as 50%.

***Jan Fooks-Bale:*** I can give you some figures. Since 2015, when we introduced the joint framework, we have inspected, in partnership with HMI Prisons, 85 of 113 establishments in England. In 39, we found failings that meant that people received services below the essential standards required by our regulations, on their first inspection. We are talking about 39 prisons, but in some cases there would be more than one provider in the prison. For example, in Exeter in August 2016, we issued three requirement notices to three different providers: the social care provider, the dental provider and the general healthcare provider. I am pleased to say that we have since been back and found that they have made the necessary improvements.

Q67 **Dr Williams:** Why aren't the providers meeting the standards? There will be a different story for each provider, but what are the general lessons you learn about why providers do not meet the standards?

***Jan Fooks-Bale:*** There are some common themes. The areas where we most frequently find failings are around things like medicines management. That is quite a broad subject, so it could be a number of things. There is person-centred care, care planning and providing services that meet people's needs. There is also the leadership and governance of the service, which is really key, closely followed by complaints management and sometimes staffing. There could be various reasons. It may simply be that the providers have not managed to meet the standards. There will be myriad reasons for that.

What is also key is the relationship between the providers and the prisons, which is the stuff Peter was talking about—being able to access people and people being able to access their appointments and the

interventions they require, and whether the care commissioned actually meets the needs of the population. That is something we saw in Liverpool, where the mental health care was not sufficient for the population, but CQC does not regulate commissioning.

Q68 **Chair:** An example of a public health measure that has been introduced in prisons would be trying to tackle smoking and making our prisons smoke-free. A question sometimes raised is whether that in itself has led to an increase in the use of NPS—new psychoactive substances—for example. Do you feel that there have been unintended consequences; or do you actually welcome wholeheartedly the public health measure on reducing smoking?

***Peter Clarke:*** I will give you a lay person's view to start with. While smoking cessation is undoubtedly a welcome thing overall, and I am sure will yield very good benefits in due course for the health of prisoners and staff alike, you cannot deny that there have been some unintended consequences. We have seen some dangerous practices, with people smoking nicotine substitute patches, for instance. I will not go into the details of how they do it, but there are some very dangerous practices indeed.

My sense is that it is very important that, if prisons are declared smoke-free, staff should take that seriously and make sure that they are all types of smoke-free. I have walked around prisons that have been, frankly, full of smoke and it has not been challenged. Only within the last three weeks, I was in a prison where the smell of drugs was very strong. I opened up a cell and found inside it two prisoners who were clearly deeply intoxicated. The signs of them smoking were all around in their cell, yet the sense I had was that the staff thought this was perfectly normal. To me, that is a sign of staff becoming inured to this sort of behaviour, and it needs to stop.

Q69 **Chair:** Are we doing enough to provide alternatives, such as vaping, or do you have concerns about the use of vaping in prison as an alternative to more harmful things?

***Paul Tarbuck:*** Initially, there were insufficient vapes available, although there was treatment from the health service with nicotine replacement therapy. Vapes were then introduced, but they were not robust enough, so they broke readily or people used them too rapidly. It seems to be settling down now where vapes are available, but people will still choose to smoke other things as well.

Q70 **Chair:** A point was raised by our first panel about unannounced inspections. Does either Professor Field or Ms Fooks-Bale have an opinion about that?

***Jan Fooks-Bale:*** In theory, we can still visit the healthcare and social care providers unannounced.

Q71 **Chair:** Can you do unannounced inspections?

***Jan Fooks-Bale:*** CQC staff do not have a legal right to enter prisons, so we have to make some kind of arrangement to enter the prisons. When we carry out our focused inspections, which are the CQC-led inspections that we sometimes do with just our staff and sometimes in partnership with HMI Prisons, we contact the governor and explain why we are coming. If we want to go in unannounced, we can request that.

I appreciate that it is a fairly small world and that there are difficulties around that; the chances of arriving unannounced are relatively slim. Sometimes we need to announce the inspections because you need the right people and the right information on site. If we were going back to look at medicines, we would want the pharmacist there. If we turn up on a Tuesday and the pharmacist visits the prison on a Friday, we would not be able to do the job we do. It is a risk assessment.

Q72 **Rosie Cooper:** Why do you not do that when you go to GP surgeries or a hospital? Those parameters must apply.

***Professor Field:*** In general medical practice and dental practice, we give notice.

Q73 **Rosie Cooper:** What about hospitals?

***Professor Field:*** In general practice, we give two weeks' notice. In hospitals, they have some time to prepare, and we do unannounced inspections; so we do have the right.

Q74 **Rosie Cooper:** But you do unannounced inspections; you have that power. You did so at Liverpool community trust.

***Professor Field:*** Correct, we did. You are absolutely correct. In NHS practice and private practice outside the prison, we can access unannounced. In the prison, we need permission to go in. That is the difference.

Q75 **Rosie Cooper:** Absolutely. That is the point I am getting to. If that is the problem, it is not an unannounced visit, however you dress it up.

***Professor Field:*** That is correct.

Q76 **Andrew Selous:** You said, "We need to ask to go in." Can you ask from outside the prison wall? Can you ring the governor and say, "I am outside; could you let me in now?"—or are you talking about ringing the week before and saying, "Can we come on Wednesday"? There is quite a difference.

***Jan Fooks-Bale:*** Yes. Generally, it would be several days in advance. We do short notice—

Q77 **Andrew Selous:** But that is not unannounced, is it?

***Jan Fooks-Bale:*** No, but around the legal requirements that is the best we can do.

Q78 **Andrew Selous:** The question I want to ask generally is this. It is fair to say that just being in prison is clearly not good for your mental health, or indeed for your physical health. I do not think there would be any dispute about that. Do you think there would be merit in the Prison Service trying to do more at the start of a sentence, particularly for people who had never been in prison before, to try to prepare them for how they are going to cope with isolation, the cell door shutting and the regime, and how they are going to keep themselves in good condition mentally and physically? Is that an area you have ever considered?

***Paul Tarbuck:*** Yes. It is an area we address in our joint inspections. Often there is insufficient support for people during that period. When a person comes into prison, in reception they are seen usually by a health professional and often a substance misuse professional. Immediate needs should be identified at that point and plans put in place to support them, which may include referral to mental health.

Also, in reception, the prison staff should be assessing for risk, and there should be some kind of peer support mechanism available, such as listeners. I appreciate that sometimes we do not see some of those things in place in the way they ought to be.

Q79 **Andrew Selous:** I was thinking more about something you could give generally to everyone coming in. I take absolutely the importance of assessment of need, but I think there is a real issue with how someone copes with their mental health generally from the cell door shutting. You have been enjoying your freedom one minute and then it is taken away from you. I imagine the impact of the change on you might well lead you to illegal substances and so on.

***Peter Clarke:*** That is absolutely right. I sometimes try to put myself in the place of the person coming into prison and think about what it would be like to go through that process and then end up in a cell by myself, or perhaps not by myself depending on the assessment. Generally speaking, I suppose the success or otherwise of that process is dependent on the induction process. What we see is that the induction process is highly variable. In some places it is very good, very thoughtful and of good quality, and involves fellow prisoners joining in and helping with buddying or whatever the particular process is. In other places, frankly, it is totally inadequate. It is very variable.

Q80 **Rosie Cooper:** The price of prison healthcare contracts is constantly being driven down. Do you have any influence or say about the low-balling of these contracts by NHSE? Accepting low bids means that a quality service is often impossible to deliver, and quality has deteriorated over time. Isn't it true when people comment that everybody is relying on the fact that there is no public clamour to improve healthcare services for prisoners? That is allowing these contract values to drop and drop and drop, until we have got to the state of Liverpool and Nottingham. I accept there is some input now, but what say do you have over those low values?

***Professor Field:*** It is a very good question, because the answer is none. This is an interesting day for CQC; we are publishing our local area review paper on people who are over 65, looking at their care across health and social care. The paper was published this morning.

We have made some recommendations, having looked at 19 of the worst-performing local authority areas, on how the care of people aged over 65 needs to be joined up and integrated; but so does the commissioning and the provision. Some of the findings from there I think would be very interesting for your review, looking at prisons.

We have no remit over commissioning, but clearly what they contract for, and the amount of money in the contract, will drive some of the provision. There are things around the edges. You know the Liverpool story better than anybody else in this country. There were issues there.

We have no legal responsibility or oversight on commissioning. We are calling for that to happen outside prisons, so that we can look at the commissioning of care, particularly for the over-65s, in adult social care and health. I think there is an interesting conundrum in prisons, in that we are looking at the provision and not the whole picture.

Q81 **Dr Williams:** I want some advice from you about what we ought to be recommending. What do you think are the most important problems that require solutions from the partners on the National Partnership Board?

***Jan Fooks-Bale:*** Prison staffing needs to be at the top of the list. We acknowledge that some action is being taken. There is also a huge national issue around recruitment and retention of healthcare staff, particularly in closed environments such as prisons.

Q82 **Dr Williams:** There are two staffing issues. There is the staffing issue within the prison environment, because it contributes to the health problems of prisoners if they cannot spend time outside their cell doing purposeful activity, and it limits the ability to take people to appointments. There is also the staffing issue within health services, because it is difficult to recruit people to work; and you made some comments about the leadership of health services.

***Jan Fooks-Bale:*** Yes, and the high use of agency staff, which is not necessarily a negative thing. We go into prisons where some of the agency staff have been there longer than some of the prison staff. They are regular agency staff who know the patient group.

Q83 **Dr Williams:** But if you have a finite budget it is going to cost more to bring in agency staff, so you are not spending it on other services.

***Jan Fooks-Bale:*** Absolutely. Recruitment and retention is an issue across health services nationally, but it is particularly acute in prisons.

***Paul Tarbuck:*** There is a lot of wastage in healthcare in prisons; "did not attend" rates are between 10% and 20%, and sometimes 30%.

**Dr Williams:** I have seen even higher than that in some prisons.

***Paul Tarbuck:*** Yes, it is hard to generalise. The issue is that there are not enough prison officers to get people to appointments, to get them out to external appointments or to enable people to get out of their cells to do wellbeing-type things. That is a really critical factor. If that could be addressed urgently, it would at least allow the NHS resources or provider in the prison to be used more fully.

Q84 **Dr Williams:** It is a total waste, isn't it? Do you need a prison officer to accompany somebody to a healthcare appointment? Is that something that has to be done by a prison officer?

***Paul Tarbuck:*** In my opinion—I am not best placed perhaps to give an opinion—in some prisons, it is not needed at all, at the lower end of security, and there are others where an escort is needed. It may not have to be a qualified prison officer. I accept that sometimes there is a need to keep certain individuals under surveillance. It seems to me that, certainly in the category B and category C prisons, the great issue is the NHS or the health resource that is already there being under-utilised.

Q85 **Dr Williams:** And that is both for appointments within the prison and for appointments outside the prison that require transfer.

***Paul Tarbuck:*** Yes.

Q86 **Dr Williams:** In one of the prisons we visited, they had invested in tele-medicine equipment. It had been there for years and was now out of date. It sat there unused because there was no service commissioned that would allow them to make use of it. There was no service commissioned from an acute hospital trust to get a doctor at the other end. Not all specialties lend themselves to tele-medicine, but that might deal with some of the issues around transfer. Of course, if they were well commissioned services, there might be some specialties that would come into the prison and be able to run occasional clinics.

***Jan Fooks-Bale:*** We see that as well, but prison staffing levels will still impact on that if you cannot get people to do the scanner or whatever it is.

***Professor Field:*** As you have an increasing ageing population, there are great similarities with outside. Some of the very innovative GP surgeries— including, for example, Whitstable in Kent—are using a lot of remote technology to work on cardiology with hospitals in London. It does not have to be the local hospital. Once you have the technology, it can be anywhere in the country.

The commissioning is key in that. How do you put the very vulnerable person or people you are dealing with right at the centre of everything you are doing, understanding the circumstances they are in? You can be quite innovative and look at how you can take things forward. That could save staff time as well.

Q87 **Dr Williams:** What should we be asking the commissioners of services, or recommending to them, from this inquiry?

***Professor Field:*** It is about patient-centred care. Patients are confined, so it is about the service that they are providing within the prison walls and the service that is available outside. Everyone should look at best practice outside. Dermatology, as you know, has been done very well remotely for years outside. There are lots of things people can do with a bit of imagination, if they go and look at outstanding care. I would say, wouldn't I, that, if you want to look at outstanding care, you should look at CQC ratings of GP surgeries and visit some of the outstanding surgeries. A lot of that care can be applied to the population in prisons as well.

Q88 **Dr Williams:** Is any outstanding care taking place in prisons?

***Professor Field:*** We do not rate prisons, therefore we cannot say they are outstanding, but we see some very good practice. The prison I went to not so long ago—Feltham—had superb dental care. The patients were captive but had better dental care than the equivalent for deprived people with poor teeth outside. We have examples of very good mental health care. There will be examples of substance misuse care. You should not just say that everything is bad. It is the unacceptable variation that is the issue.

Q89 **Dr Williams:** Why don't you rate them?

***Professor Field:*** We do not have regulatory power to rate prisons. We rate the NHS and private providers if they are registered with us for care outside the prison.

Q90 **Dr Williams:** Why can't you give them a rating for the care they are providing in the prison?

***Professor Field:*** We cannot legally at the moment.

Q91 **Dr Williams:** Should you be able to?

***Professor Field:*** We have not yet had a discussion about how that might be taken forward, because it is not within our power. Again, if you look at what we are suggesting for outside prisons, we think, going forward, that you should look at the commissioning and the provision of care.

There is an argument on ratings: if a prison does substance misuse, mental health, general practice and dentistry, what is different in that from looking at a hospital that has maternity, surgery, medicine, emergency medicine, and so on? There is a theoretical framework that you could put together, but we have not yet had that discussion because it is not within our power. The inspection process is working very well.

Q92 **Dr Williams:** Who can give you that power?

***Professor Field:*** You guys. It's law.

Q93 **Rosie Cooper:** When you evaluated and rated Liverpool community trust, did you inspect the prison element of it? You made comments about it. I need to check—it is three or four years ago—but I remember you doing that.

***Professor Field:*** It is true. If we found poor provision in, let's say, Liverpool, or if we found poor leadership in the trust providing that care, we would then cross-check. Theoretically, that, in Liverpool prison, would inform the overall rating from a well-led point of view. There are ways. We need to look at it, and improve that and take it forward.

Q94 **Chair:** Steve, is there anything to stop you giving a rating? If we are going to allow people to say what good looks like, and there is no rating, how do they know where to look within the Prison Service for what is working well?

***Professor Field:*** Outside prisons, it comes from the regulations. If we are going into Torquay hospital or Exeter hospital, that is—

Q95 **Chair:** I understand how it works outside in hospitals. Are you saying that you are actively not allowed to give a rating when you inspect facilities inside prison?

***Professor Field:*** In an average prison—although there is no average prison—they might have four or five different providers going in. It would have to be a different way of doing it from what we do now. We have not yet had a discussion and debate about the advantages and disadvantages.

Q96 **Chair:** Do you feel it would be helpful if you could rate the healthcare in a prison?

***Professor Field:*** If we had a rating system that involved commissioning, it would be more transparent and obvious for people. The problem is that prisoners themselves do not have a choice about which prison they go to.

**Chair:** Exactly.

***Professor Field:*** For me, it is about transparency, so that everyone can know what the care is like, so that you can exercise levers and try to improve things. Where we are at the moment actually works very well—a joint set of working with HMIP. What we have not yet moved to is a discussion about ratings.

Q97 **Rosie Cooper:** Hang on, how can you say that is working well? If I were you guys, I would be ashamed that you presided over that time of healthcare provision in Liverpool and Nottingham. You presided over that, so it is not working well. It went on and on and on. It took a lot of whistleblowing and a lot of energy from people to bring everybody to the table. In fact, I was giving the CQC information that you guys could not get from the prison in Liverpool yourselves. You asked me for the information. I gave it to you in 10 minutes.

***Professor Field:*** That's true.

**Rosie Cooper:** Exactly. I would be ashamed. How do you improve it? How do you get your hands on the levers of power to make sure that people attend to what you say? Ratings would be one of the ways of saying, looking across the country, "This is not good." People need to deal with it. You cannot just comment on it and walk away.

***Professor Field:*** I agree with you. In a way, it is access to the information to make the judgment that is key, whether you have ratings or not. Outside the prison world, we rate GP surgeries, but actually we take enforcement action alongside that based on the fundamental standards as well. If you are an inadequate surgery, it is likely that we have taken enforcement.

The problem you suggest happened is one of the information you have and how you can then act on that.

Q98 **Rosie Cooper:** The Government would notice; the Ministry of Justice might get a clue; and you might be signalling that somebody in authority needs to pay attention before we get to the terrible states, which I have described as a national disgrace, of those two prisons. If you want a question from me it would be, how do you stop it getting that far?

***Peter Clarke:*** In terms of prison inspection, perhaps I can help. The difficulty with prison inspection over the past few years is that, to be quite frank, not enough notice has been taken of our inspection reports and of recommendations. We are an inspectorate; we are not a regulator with all that goes with that. We are a very small body.

I would like to think—I am not a hopeless optimist about this—that several things that have happened in the past year will change that. First of all, a year ago, a prison's response to recommendations of the inspectorate was removed from the key performance indicators of prisons. It became a moderating factor as opposed to a mainstream performance indicator. That has now been reinstated, and the Prisons Minister is absolutely clear that response to inspectorate recommendations will be front and central in judging the performance of prisons.

**Chair:** This is part of Johnny's questioning about driving improvements. Perhaps we should come to that section next.

Q99 **Johnny Mercer:** You said that there are areas of really good practice. You have talked about areas of really good healthcare. The general public, who ultimately pay for all of this, want to know where the forum is that is bringing those together. Why is that not happening? Clearly some of the outcomes you are talking about are not acceptable, but the sharing does not seem to take place. Why is that, and how are we going to make it happen?

***Peter Clarke:*** That was going to be the second limb of my answer.

**Johnny Mercer:** Fantastic.

***Peter Clarke:*** Making sure of a response to inspectorate recommendations is one thing. The second part is that the MOJ, in the past year, has actually formed a unit. I am always as sceptical as anybody about a new unit, but a new unit has been formed whose sole raison d'être is to pick up inspectorate recommendations and best practice as identified in our reports, and to promulgate them.

Q100 **Johnny Mercer:** And that is happening only now, in 2018.

***Peter Clarke:*** That has happened only within the last 12 months. The unit has been formed.

The third limb is the urgent notification process, which we have now used twice. Healthcare has been a part of that process. Again, I wait to see the impact of that. If I may, I will not quote the prison governor by name, but a prison governor said to me very recently, "The urgent notification process and the response to it has revolutionised the Prison Service and its response to inspectorate recommendations."

The fourth element is that, thanks to the Justice Select Committee and their evidence hearing in January over Liverpool, the inspectorate has just within the last few weeks been granted extra resource to increase our capability to follow up and report outside the normal routine of inspection processes. Those are four things that I very much hope will contribute to the impact. My whole strategic objective with the prisons inspectorate is increasing the impact of inspection; otherwise we might as well not bother.

Q101 **Johnny Mercer:** Why hasn't the previous incumbent of your position come up with that?

***Peter Clarke:*** That is not for me to ask questions about. I am just doing what I try to do.

Q102 **Johnny Mercer:** It is slightly deflating, isn't it, for people who work in the Prison Service? I visit Dartmoor prison and they feel exactly this way—that there is good practice around but they are just on their own.

***Peter Clarke:*** I find it very depressing. At Northumberland prison, there is a unit specifically dedicated to the care of older prisoners. I saw it for myself. I saw that it was a very good and caring environment. To quote some of the older prisoners there, they said to me: "We love being in here because we look after each other and we are away from the drugs and the violence and the noise in the main wings." In other places in the country, I have said, "Have you seen what is happening in house block G in Northumberland?" and the response is, "Where? No."

Q103 **Johnny Mercer:** That is my problem with this. No private sector organisation would ever survive that.

***Peter Clarke:*** That is why I am so disappointed; there does not appear to be a coherent national strategy to deal with older prisoners, and the

inevitable demographics of the next few years are that we will have an older population of prisoners.

***Paul Tarbuck:*** I have some information that might help. About two years ago, the National Audit Office suggested that we should better demonstrate the impact of what we do. In the last year, we have put a good practice element on our website, so you will actually see some evidence of good practice that we are trying to disseminate via the website.

It is complex, though. For example, two or three weeks ago I was in a prison where we cited exemplary practice in resuscitation, yet the mental health service there was deficient because they hadn't enough staff to offer things like primary care or support for depression. Even though we cite good practice, it may not give a true impression of the whole service.

Q104 **Johnny Mercer:** Do you think you are getting good enough prison governors, for the money you pay them, to look outside the strategic vision, as any worker at that level would be expected to do, and think, "How am I going to raise the standards in this place?" It really does not seem like rocket science.

***Peter Clarke:*** That is probably more a question for me. First of all, we do not pay them and we do not employ them. We inspect them.

Q105 **Johnny Mercer:** Are they good enough?

***Peter Clarke:*** Do I see variations in levels of leadership? Yes. Do we now comment on the impact of leadership and management in prisons? We do now. We used not to. We do it not as a management consultancy but in terms of the impact on outcomes. If we see an impact, good or bad, we ask ourselves, "How has that happened? Is it because of good or poor leadership?" We now comment on it in our reports, so it is a fairly recent departure from previous practice.

Q106 **Luciana Berger:** I want to go back a bit. This is part of the same theme, but it is specifically about the effectiveness of the inspection regime. You talked a bit about the baseline and the challenges of not having a robust baseline. You have drawn on some of the figures that show, in your view, how many institutions can be a cause for concern in terms of what you inspected.

I have a few specific questions about whether you think more needs to be done on the timespans between when you might inspect prisons, and particularly whether you think the time since the last inspection, as it currently stands, is acceptable and effective. How soon after a change in leadership do you think an establishment should be inspected? What intelligence do you need to receive in order to prompt an inspection? There is more, but those are the key factors.

***Jan Fooks-Bale:*** I will talk about what the CQC does as part of the bigger package. In 2017-18, we completed jointly 41 scheduled

inspections; 19 of those providers failed to meet essential standards. Once the providers provide us with an action plan to say what they are going to do about that, we risk-assess it and we go back and inspect. It depends what the issues are as to how quickly we go back and inspect.

We have already followed up seven of those, and there is an ongoing programme. In fact, my inspectors are going into Holme House this week. In 2017-18, we also completed 20 focused inspections to follow up on failings that we found during 2016-17. All those reports are published on the CQC's website. In terms of driving improvement, we jointly report on the initial inspection that identifies breaches of our regulations, how people's needs are not being met and the impact on people. The focused inspections are reported on the CQC website, so that information is in the public domain.

I can't remember the last bit of the question.

Q107 **Luciana Berger:** It was about whether there is an acceptable length of time and what intelligence you would need to receive to prompt you.

***Jan Fooks-Bale:*** I will give you an example of monitoring. At HMP Wymott, the main service is provided by Bridgewater community trust. About this time last year, we started to receive a group of complaints from whistleblowers, some of which had a safeguarding element. I think we received nearly 30 of these contacts. We worked with our colleagues who provide the main relationship with Bridgewater trust and with NHS England commissioners to identify what the issues were and to monitor them.

NHS England put in a turnaround team, who left in April. In the meantime, we have been monitoring progress there. There was a lot of, "Should we go in and inspect or not? Should we let them make the improvements that needed to be made?" We closely monitored progress there. The turnaround team has left. We are not sure that improvement has been sustained, and we will be going in later this month. That inspection was announced yesterday. We are going in to test the sustainability of the improvements that have been made there. That is an example of how we use intelligence and monitor the service.

Q108 **Luciana Berger:** With all those things, do you want any changes? I am most keen to know what, if anything, we need to amend to allow you to ensure that that regime is as effective as possible. Is there anything you want to do differently to make it more effective?

***Jan Fooks-Bale:*** I am sorry; can you repeat the question?

**Luciana Berger:** We are focusing on the effectiveness of the inspection regime. At the moment, you have very set processes in place to determine when you go in to do an inspection, and the type and size of establishments that you go to: if there are any changes to an establishment, would that prompt an inspection or not; if there are changes in leadership; and what intelligence you receive. I just wondered

whether you think that all those different elements are robust enough, or whether there might need to be some changes to make them more effective.

***Jan Fooks-Bale:*** In terms of what the CQC can do, if we receive intelligence, or it comes out of our monitoring, we have a process by which we risk-assess that. We hold a management review meeting and we decide what we need to do from our scale of enforcement action. It might include going in to inspect and to seek more information.

***Professor Field:*** Our enforcement action includes being able to give a warning notice with a specific timescale for delivery. We can move on to criminal action if we need to. The enforcement procedures we have are the same as outside. The issue before that is whether we have enough intelligence to decide how to risk-manage when we go in to inspect. That depends on where the information comes from. We act when we get the information.

***Paul Tarbuck:*** Colleagues from the CQC share appropriate information with us. We have a regular meeting at which the schedule of inspections is addressed. Within that, there are slots for prisons of high risk, so the information is fed into those particular deliberations. The sequencing of a prison could be brought forward if the risks were thought to be high enough.

Q109 **Mr Bradshaw:** Forgive me if you were asked this question at the beginning, just before I came in. Given what you have all said about drugs, has your experience in this field caused you to question whether it makes sense to lock up in prison a lot of people who have drug abuse problems and treat it as a criminal justice problem rather than as a health problem? Do you question whether that is a sensible thing for the health of the country in general and for prisoners in particular?

***Peter Clarke:*** As the chief inspector of prisons, I am, I hope, meticulous in never commenting on sentencing policy, because that is clearly a matter for Government and the courts. What is of concern to me is the prevalence of drugs in prison, and in particular the ease with which people can get hold of drugs.

Part of our methodology is that we conduct a survey whenever we inspect. On average, around 40% of prisoners say that it is easy or very easy to get hold of drugs. Even more concerning, if it could be more concerning than that, is the fact that it is not unusual for 15% to 20% of prisoners to say that they have acquired a drug habit while they are in prison. To my mind, that means that whatever the drug supply reduction strategy is in particular establishments, it is not working, but I would not take a view on whether people vulnerable to substance misuse or whatever should or should not be put into prison. That is not a matter for the inspectorate.

Q110 **Mr Bradshaw:** Are any of the others less restricted than Mr Clarke in

commenting on what you really believe on this?

***Paul Tarbuck:*** People who have an addiction need help to conquer the addiction. Providing the help is available, it is really not an issue from a health perspective whether they are in prison or in the community. The right help should be available at the right time from competent people.

There are some issues about having services in place in prisons, but I am sure there are problems in the community as well. From a health perspective, there are some technical issues that are slightly more difficult in prison, such as the use of certain medications and not others that fall within national clinical guidelines, because of things like security reasons, which we challenge when we come across them. The treatment should be available if the person has a problem that can have an appropriate clinical response.

***Jan Fooks-Bale:*** What is really required for an individual is that the establishment has a joined-up strategy that looks at the clinical side of things and the security side—supply reduction and the support offered to both prisoners and to staff to manage it.

Q111 **Mr Bradshaw:** You are not aware of evidence from other countries that treat substance abuse as a health rather than a criminal justice issue that there is less of a problem with drugs in prisons. That is not something you have come across in your work or research.

***Paul Tarbuck:*** There is research, but different studies in different cultures come up with different results. It is quite difficult to make a judgment, but there are certainly studies that show that simply to criminalise someone because of an addiction may actually compound the issues and not help them. There are some studies that say that.

**Mr Bradshaw:** If you can identify any of those and perhaps point us in their direction, they might be helpful for the Committee. Thank you.

Q112 **Andrew Selous:** Following on from the drugs theme, the information you gave us, Peter, was that 13% of men and 8% of women had developed a problem with illicit drugs while in prison. The figures you have given us are even more shocking than that; 15% to 20% of prisoners in some cases, you said, are becoming addicted in prison. What do we need to do differently to reduce that?

Those are figures that should shame us all. Have you thought about drug testing on arrival? Are there different types of regime that are more effective? We have some drug-free wings—it sounds an odd phrase, doesn't it, when talking about a prison? We would hope that every wing of the whole prison would be drug-free? They exist in some parts of the country, with separate regimes, where there is co-operation.

As the chief inspector, are there any changes you would like to see to drive down drug usage in prison, both of people coming in who already have a habit and continue it within the prison walls, and, even more worryingly, those who become addicted in prison? What do we need to do

differently to get on top of this?

***Peter Clarke:*** Jan was absolutely right just now when she said there has to be what is sometimes termed a whole prison approach to reducing both supply and demand. It is all very well doing mandatory drug testing, which tells you—

Q113 **Andrew Selous:** But does that happen on arrival for all prisoners? I do not believe it does, does it?

***Peter Clarke:*** No, I do not think it does.

Q114 **Andrew Selous:** Can we get some clarity on that?

***Peter Clarke:*** There is a screening, when that sort of issue will be inquired about, but I do not think there is a mandatory test.

Q115 **Andrew Selous:** But if I go into a prison and I do not want to reveal my drug usage, I am not going to be regularly tested, am I, during my induction?

***Paul Tarbuck:*** That is correct, but you could be randomly tested.

Q116 **Andrew Selous:** I could get in as an addict and you would not know about it. Then, if I develop a habit, it is only whether I am picked up randomly if I do not reveal it and do not want help.

***Paul Tarbuck:*** If you do not reveal it and your behaviours do not reveal it, that is possible.

***Peter Clarke:*** The issue is that, if a mandatory drug testing regime—which prisons have—reveals some really troubling data, it has to be acted on. At Liverpool, when we last inspected there, the combined MDT test—the mandatory drug testing—was positive in 41%.[1] That tells you something pretty troubling about the prison and the response, and about the number of times I am told, "Oh, we have a comprehensive drug supply reduction strategy and it's been in place for three years," and we have to say, "Well, it's not working."

Q117 **Andrew Selous:** What happened in Liverpool to get it down from 41%?

***Peter Clarke:*** What is happening is that two weeks ago I paid an informal visit to Liverpool prison, not an inspection, and I saw a huge amount of energy, dynamism and leadership going into all areas of the prison that had been identified on our last inspection, last September. It was very heartening. It is probably too early to say what the results will be, but it was difficult to see, from what I saw two weeks ago, how they could be anything but positive.

There is a long way to go. A comprehensive drug strategy for a prison really has to encompass everything, from securing the perimeters of the

[1] "Note by witness: This figure is incorrect. The correct figure for the combined mandatory drug testing rate at the time of inspection was 37.5%."

prison through to effective intelligence, security and detection, and treatment and support for those who use various substances.

Q118 **Andrew Selous:** Have you seen any prisons that have really got on top of the drugs issue recently?

***Peter Clarke:*** I have seen some good work going on in some places, but off the top of my head I would hesitate to identify a particular prison and say that it has solved it. If you want some examples of good practice, we can certainly supply the Committee with them.

Q119 **Rosie Cooper:** Bridgewater is challenged, both as a community trust and a provider of prison healthcare. You described NHSE's investment and turnaround team, and said that it might not be being sustained and that you are going to make an announced inspection. Do you think this is just prolonging the agony and that if you actually did an unannounced visit you would find the real tale?

This is a trust that is very challenged and has been over the last three or four years. If it has had a turnaround team and it is not sustaining it, surely by going in unannounced you would get a proper version of what is going on, instead of just putting it further down the line.

***Jan Fooks-Bale:*** When we go in, whether it is unannounced or announced, we plan to go in for more than one day. Off the top of my head, I cannot remember how many days, but it is several days. During that time, we will look at records. We will talk to prison staff and healthcare staff. We will talk to the governor and to patients. While I appreciate that they know we are coming and can put more staff on, if that was the issue, it is very difficult to present a positive picture over several days if there are true failings.

Q120 **Rosie Cooper:** While I genuinely appreciate that, if you look at LCH, on one visit, you said they were good; on the next one, they were poor; and on the next prison visit, they were good again. I am only speaking about the facts as they are already established. You need to do unannounced visits and really go at it hard.

***Professor Field:*** We do not disagree with you. We can do unannounced visits. The issue there is what you find, how you act and how the response comes. We can use our enforcement procedures right the way through civil and criminal action, and then a response is needed. There is also a response needed from the commissioners of that service in the first place. In a way, we are the inspectorate; we monitor, inspect and enforce. The commissioners actually pay for the service and are the ones responsible for the contract between them. They have a responsibility as well. It is not just the inspectorate. We do what we can within the law, but other people are responsible as well.

My final point is that actually it is the people who are providing the care who are really responsible. They are the ones we should be changing.

**Chair:** That is an issue that has been raised before—responsibility for commissioners to make sure that services are being provided. Thank you for that, and we thank all of you for coming this afternoon.