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Incarceration: Humane and Inhumane

Human Values and Health Care in British Prisons

Edited by
Stuart Horner
and
Meg Stacey

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FOREWORD
By John Wyn Owen, CB

PREFACE. A CELEBRATION OF GRESHAM COLLEGE
The dedication of the conference to the 400th anniversary of Gresham College; the presentation of a commemorative goblet by Dr Watney of Gresham College Council to Sir Alexander Macara, chairperson of the Human Values in Health Care Forum.

CHAPTER 1. INTRODUCTION
Stuart Horner
Sets the conference in the founding aims of the Forum and outlines the papers to follow.

CHAPTER 2. HEALTH CARE AND THE LESSONS OF HISTORY
Joe Sim
Describes 200 years of reliance on prisons and of their failures pointing to historical continuities: prisoners' ill health; seeing prisoners as malingerers; applying 'less eligibility' to prison health care. Applies these lessons to health care in contemporary prisons, questions the wisdom of involving the NHS; questions the possibility of a 'healthy prison'. Calls for a radical redistribution of resources and non-punitive philosophies involving care, compassion and empathy.

CHAPTER 3. HUMAN VALUES AND DEATHS IN PRISON
Tony Ward and Deborah Coles
Argue that prison is deeply inimical to human values: a not untypical example, the death in Belmarsh Prison on 25/11/95 of Kenneth Severin a mentally ill young African Caribbean man who died alone and naked in a strip cell is described and analysed using

evidence from the inquest. Preoccupation with discipline, rather than health; the lack of knowledge about the man as a person; the lack of individual responsibility for his death; the separation of action from ethics are revealed - a separation also demonstrated in deaths in police custody. A moral vacuum where the state impinges on individual lives is postulated.

CHAPTER 4. PRISON CHAPLAINCY AND PRISONERS' HEALTH CARE AT A TIME OF GROWING RELIGIOUS DIVERSITY

Jim Beckford and Sophie Gillant

Report the decline in the proportion of prisoners registering as Christian; a steep increase in those who register with no religious group; growth in the proportion of other faiths. Yet, consequent upon the Church of England's statutory responsibility to provide a clergyman for every prison, other faiths are dependent on the 'brokerage' of Christian, usually Anglican, chaplains for access to their members in prison. Issues reported included statutory duties (e.g. reception into prison) being carried out only by Christians; lack of training for 'visiting ministers'; loss of potentially valuable help in overcoming collective difficulties; the difficulty of providing 'whole person' health care; the failure to draw on visiting ministers in cases of illness including mental illness.

CHAPTER 5. PRISON HEALTH CARE IN ENGLAND AND WALES: VISION AND VALUES

Mike Longfield

Discusses and spells out professional codes of conduct; the statutory frameworks for operating prisons; the various ethical declarations regarding the treatment of prisoners, national and international; the British Medical Association's reports which stress the duties of prison doctors and their need for independence.

Enunciates the key principles underpinning contemporary prison health care, the strategic aims for their development, health promotion in prisons; already existing implementation (eg. *Health Promoting Prisons Awards Scheme);* and raises future relations between the NHS. and the Prison Service.

CHAPTER 6. GENERAL DISCUSSION

Stuart Horner and Meg Stacey

Summarizes three main emergent themes from the discussion: the lack of clarity about whom and what prisons are for; the role of health care professionals in prisons; how to balance the demands of security and those of providing health care; the use of resources; the gap between vision and actuality and the changes afoot.

CHAPTER 7. CONCLUSION

Meg Stacey

Draws out major points from the conference showing the continuing unacceptable practices: deficiencies in health care, including serious deficiencies in the spiritual care of prisoners and *de facto* discrimination against ethnic minorities and faiths other than Christian; the plans for improvement and the beginnings of implementation. Regrets that no contribution was invited from a prisoner or ex-prisoner but draws attention to the addition available in Appendix **1.**

APPENDIX 1. THE PRISONER'S TALE

Prepared by Stuart Horner

Edited extracts from ONE OFF
by Andrzy Jakubczyk and Paul D Ross

An account of prison life with special reference to suicide in prison and its causes and of the difficulties the authors experienced in writing the account, not hitherto formally published.

THE CONTRIBUTORS

JAMES BECKFORD is a Professor of Sociology at the University of Warwick. His publications include *The Trumpet of Prophecy; A Sociological Analysis of Jehovah's Witnesses* (1975), *Cult Controversies; The Societal Response to New Religious Movements* (1985); *Religion and Advanced Industrial Society* (1989); and (with Sophie Gilliat) *Religion in Prison: Equal Rites in a Multi-Faith Society}* (1998). He is currently Vice-President of the International Sociological Association and President-elect of the International Society for the Sociology of Religion. His research is concerned with religious controversies, chaplaincies and the relationship between religion and politics.

DEBORAH COLES has been Co-director of INQUEST since 1990. She previously worked in the field of penal reform and is on the management committees of Women in Prison and the Prisoners' Advice Service. She is co-author of a paper *Prison Suicides: How Not to Prevent Them* (with Tony Ward 1994); *Racial Discrimination and Deaths in Custody*, INQUEST report to the United Nations Committee on the Elimination of Racial Discrimination (with Helen Shaw 1996) and *Suspicious Deaths in Police Custody* (with Tony Ward 1997).

SOPHIE GILLIAT-RAY read religious studies at the University of Wales Lampeter, gaining a PhD on Islam in Britain. In 1994 she moved to the Sociology Department at the University of Warwick to work with Professor Beckford on the Church of England and Other Faiths Project, writing with him *Religion in Prison: Equal Rites in a Multi-Faith Society?* (1998). She has followed this with work on theological education for a multi-faith Britain, looking at how the clergy are trained to work in religiously diverse contexts. She is currently convenor of the British Sociological Association's Study Group on the Sociology of Religion and now holds a

Research Fellowship in the Department of Religious Studies at Cardiff University.

STUART HORNER is Visiting Professor in Medical Ethics at the University of Central Lancashire in Preston. After qualifying in Medicine at Birmingham University and initial hospital posts, he entered his chosen specialty of Public Health, reaching senior posts early in his career and retiring in 1996 as Director of Health in North West Lancashire. He was a co-founder of the Human Values Forum. He has taken an active role within the British Medical Association throughout his professional career and served as chair of its Medical Ethics Committee for eight years. He is now a Vice-President. In 1995 he was awarded an MD at Manchester University for a thesis on Medical Ethics. Since leaving the National Health Service he has contributed to a number of books on ethical matters in Medicine, usually from a Christian perspective.

MIKE LONGFIELD MB ChB MHM, Director of Health Care, HM Prison Service, trained as a doctor at Manchester Medical School and, following the usual 'house jobs' in medicine and surgery, went on to train as a general practitioner in West Yorkshire. In 1983 Mike joined the Prison Service as a medical officer in Armley Jail in Leeds, quickly gaining promotion to senior medical officer in charge of medical services at Wakefield Prison and at Leeds. Since 1990 Mike has worked at Prison Service Headquarters, initially with responsibility for oversight of the health care arrangements in prisons in the South Thames region (Prison Service Areas, Kent, London South and South Coast) and from April 1996 in the capacity of Director of Health Care for prisons in England and Wales. Mike's outside interests centre on family life with his wife and two teenage boys, at their home in Sussex.

JOE SIM is Professor of Criminology in the School of Law and Applied Social Studies, Liverpool John Moores University. He has been involved in researching and writing about prisons since 1975 and has written extensively on the subject. These writings include a number of co-authored and co-edited texts: *British Prisons, Prisons Under Protest* and *Western European Penal Systems.* He has also written *Medical Power in Prisons,* which is a history of the Prison Medical Service up to 1989, and delivered the 1993 annual Prison Service Perrie Lecture on the same subject. He is hoping to conduct further research in this area, under the auspices of the Nuffield Foundation and is also preparing a new book on the recent history of prisons, entitled *The Carceral State,* which will be published by Sage in 1999.

MEG STACEY is Emeritus Professor of Sociology, University of Warwick. Beginning as a general sociologist, she published *Tradition and Change: a Study of Banbury* in 1960. For the past thirty five years she has focused on the sociology of health, illness and healing. *(The Sociology of Health and Healing: a textbook,* 1988). A one-time member of the General Medical Council, she has researched professions and professionalism *(Regulating British Medicine: The General Medical Council,* 1992). Her interests also include the social and human value implications of high technology medicine *(Changing Human Reproduction: social science perspectives,* ed. 1992).

TONY WARD PhD is Senior Lecturer in Law at De Montford University, Leicester. After qualifying as a barrister in 1981, he worked for Radical Alternatives to Prison (where he took a particular interest in medical issues) and was Co-Director of INQUEST from 1982 to 1990. His publications include *Privatization and the Penal System* (with Mick Ryan, 1989), *Deaths in*

Custody: International Perspectives (co-ed. with Alison Liebling, 1994) and contributions to *Legal Medicine in History* (M J Clarke and C Crawford eds. 1994) and *The Health of Prisoners: a Historical Symposium* (W F Bynum and R Creese, eds. 1995)

FOREWORD

The health of prisoners is an emerging priority issue for the NHS. Recent enquiries, such as Caldicott into Ashworth, are a reflection that change is necessary. By and large health service administrators are unaware of the issues and if integration into mainstream health services is to occur, then this Nuffield Trust publication will be an important contribution to informing those who will have new policy and operational responsibilities.

It was Judge Stephen Tumin, a fellow guest at a Nuffield Trust dinner, who alerted me to the issue of the health of prisoners when I was Director of the NHS in Wales and encouraged me to visit Cardiff Prison to explore at first hand the extent of health provision in prisons. During my time as Director-General of the New South Wales Health Department, the health of prisoners featured significantly as the government of New South Wales established the Corrections Health Service, with the Health Department taking over responsibility from Corrections, the running of medical services in prisons.

These experiences have led me to the conclusion that the appropriate allocation of responsibilities between the Prison Service and the Health Service can make a significant contribution to each service, though there will continue to be significant tensions between a caring health regime and that of the Prison Service generally.

John Wyn Owen, CB
London: 1999

PREFACE

A CELEBRATION OF GRESHAM COLLEGE

During 1998 Gresham College celebrated its 400th anniversary and the Human Values in Health Care Forum dedicated this conference to that anniversary. Dr. Duncan Watney attended the conference on behalf of the College and presented a cut glass goblet to the Forum to mark the occasion.

Dr Duncan Watney said,

> I am here mainly because I am a member of the Council at Gresham College. I am doubly happy, however, that I have attended, since I am a retired general practitioner with a particular interest in health matters and I have been a magistrate for over thirty years. These three reasons have made the conference particularly interesting to me and I have had a very, very interesting day.
>
> Some of you may not know about Gresham College. A couple of words at this juncture may be interesting. We are in fact celebrating our 400th anniversary of the start of Gresham College, which was founded in Thomas Gresham's will. He died in 1579 and the College began in 1597. In his will Thomas Gresham left his house to be used as a college for the use of the inhabitants of London. He decided that there should be seven professors in physic, law, rhetoric, divinity, music, geometry and astronomy. He was very forward thinking. These professors were there, he decided, to sell the new learning of the Renaissance to the citizens of London. The idea was that there should be no students; there were to be seven professors but no students, so that it was free for anyone to come. The

pattern goes on to the present day. There is a very good programme of lectures. For anyone who lives in London, or can get to London, there is a series of lectures. They only last an hour and usually they are given either at lunch-time or at 5 o'clock in the evening. The subjects are presented by some very, very eminent people who are our current professors. They are given a small stipend to come and each of them gives three lectures a term. They're right at the 'cutting edge'. We have had interesting seminars on life on Mars from Professor Pillinger, our Professor of Astronomy. Recently we have appointed a Professor of Commerce as well. So there are now eight professors.

Thomas Gresham founded the Royal Exchange, which is now managed jointly by the Corporation of the City of London and the Mercers Livery Company. I am a Livery man in the Mercers Company and Thomas Gresham was our Master, in fact, in the year he died, 1579. I was Master in 1944, so there is a long distance between us. It is a wonderful thing to be able to take on. There is an extraordinary committee called the 'Joint Grand Gresham Committee', which runs the Royal Exchange and it is the rents from the Royal Exchange which fund Gresham College. The rents are divided between the Mercers Company and the City Corporation and then come into Gresham College. The College itself is at Barnard's Inn, which is just down the way in Holborn. Barnard's Inn was a sort of small cousin of Gray's Inn. It is fascinating that we are here virtually in Gray's Inn Road and that we have re-established our relationship with the Forum in the last

year or two. The College Council actually meets in the old dining hall of Barnard's Inn, which was built in the seventeenth century - I have forgotten the date. It is a beautiful little place. If you want to know more about Gresham College, we are on the Worldwide Web at www.gresham.ac.uk. Or, if you want to find out about the lectures, they are on E-mail at enquiries@gresham.ac.uk.

I feel that we are so fortunate to be in the situation at Gresham College of being able to give money to the kind of work which the Forum is doing. We are able to fund things because we are totally non-aligned and we can do things just 'out of the blue'. The Council receives a number of interesting things that we might fund and the Human Values in Health Care Forum is one of them. I think it is marvellous.

For me this has been a fascinating day and I thank you so very much for inviting me to come. I am very, very grateful. Just as an interesting sort of little token, I want to present your chairman a goblet which is engraved with the dates of the founding and the quad centenary of the College.

The chairman, Dr. A W Macara (now Sir Alexander), then responded on behalf of the Forum. He said,

Thank you very much. Can I say first of all a personal word: we do appreciate enormously, not only your presenting us with this splendid symbol, about which I shall say something more in a moment, but for coming

along personally to do it, when we know that you do have your wife to look after and that she might have asked you to come home at any minute. We trust that you will thank her for letting you stay with us as long as you have done and we wish you God speed on your return.

Now, having said that, can I just say what a magnificent example this is of reciprocal self interest. It is mutual interest in education - in the cause of education. In this case, if you like, of multi-disciplinary learning within education, which carries the 400 year old tradition of the seven professorships, marvellously without students. Think of it, those of us who have been academics, who are academics - the seven and now the eight have chairs. The support of Gresham College has been important for this Forum. When Huw Francis, Stuart Horner, a very dear friend Alistair Nelson (who has now sadly moved on) and I decided to set up this little group with the objectives of which you are so aware, we looked around for financial support. I will not tell you where we did not obtain it, except to say that we did look at semi-commercial possible sources of support. It was Huw who had this brilliant idea that we should look for an educational source for our support. We found another very good friend, Professor Sir Kenneth Stuart, whom you will know Dr. Watney, a very distinguished man who was at that time a professor of physic, I think I am right in saying. It was Ken who said, 'Well do you know, I think the Provost might be interested in what you are planning to do'. He was indeed! We owe our continued existence

> and the work we are able to do to Gresham College. I am thrilled that the committee has now given a lead in an even more multi-disciplinary direction. We owe an enormous debt of gratitude to Gresham and we would, I am sure, ask you to report back to the Council of the College our delight at this symbol, because a goblet is a symbol, isn't it? One thinks of the Holy Grail; one thinks of Loving Cups; one thinks, not least, of the splendid things that you can put in it. If you have a mind, share and if you have not, not - as the case may be. It is a lovely, loving symbol and it is a symbol of a relationship in which we in the Forum take great pride and pleasure. Thank you very much again.

The conference applauded this celebration.

1. INTRODUCTION

Human Values and Health Care in British Prisons Stuart Horner

This volume records the proceedings of a conference dedicated to the quadcentenary of Gresham college in 1997. That year also saw the fiftieth anniversary of the conclusion of the medical trials in Nuremberg - a fitting time to visit the subject of health care in British prisons. The four public health doctors whose deliberations led to the foundation of the Forum were concerned by the implications of the Nazi holocaust in the German occupied territories and the active participation of doctors in the human abuses which occurred. German doctors had been frustrated by their inability to obtain independent professional status. Some of them actively supported the Nazi movement and doctors were over-represented in the National Socialist Party. Their early support for National Socialism was rewarded by national status as a free profession in 1935.[1] Not all doctors were involved. There were doctors and other health care workers who resisted, at great personal cost, the National Socialist Programme. Furthermore, many of the predisposing factors which led to the elimination of 'undesirables' were of medical origin and based on mistaken eugenic theories, which, from early in the twentieth century, and particularly in the 1920s and 1930s, were widespread in Western Medicine.

As Joe Sim points out in this volume[2], doctors put their full professional and ideological weight behind the demand for punitive discipline in British prisons during the nineteenth century and one of the case studies by Tony Ward and Deborah Coles[3] leaves an uneasy feeling that such attitudes may still exist at the present time. Indeed historically, doctors have a depressing record of support for oppressive regimes. Although Dr Benjamin Rush signed the American Declaration of Independence, Dr Guillotin invented a machine which became the symbol of political terror. In sixteenth century Europe as Porter[4] reminds us, ' ... most early-modern doctors supported the prosecution of witches ...' even though we

now know that the witch craze was probably a social response to population[5] and other changes.

The founders of the Forum hoped that it would address two key issues. First, could the abuses happen in this country; and secondly, could they be prevented? The papers at this conference showed that there are indeed conditions occurring at the present time which contain the same seeds as those which produced the dreadful harvest of the Holocaust. Tony Ward and Deborah Coles (Chap 3), quoting Bauman, refer to a 'terrifying contraption', the bureaucratic apparatus of the modern state, which has 'an inherent tendency to produce a moral vacuum at the point where it impinges on individuals' lives'.[6] Although Joe Sim (Chap 2) does not pick up contemporary analogies to the historical record, they are not difficult to find. The case studies in the second paper reveal terrifying examples of individuals disobeying or ignoring rules and guidelines and health care professionals either uninvolved or inadequately involved in the care of potentially sick prisoners. Suicide in prison is much more common than outside, even among young adult males, the group most at risk. Prison doctors continue to express ethical concerns to the British Medical Association and the continuing difficulties in recruitment make it difficult to maintain and improve the quality of medical care in prison, despite the obvious desire of Mike Longfield (Chap 5) to achieve good quality health care in the prison environment. The current public debate about chaining of prisoners when outside the custodial institution, and even at times like the latter stages of terminal illness and early in the second stage of labour when the risk of both escape and violence would appear to be minimal, draws attention to the potentially dangerous mental attitudes common in all custodial institutions. Such attitudes concentrate more on the need to process individuals than upon the individuals themselves. As Tony

Ward and Deborah Coles remind us[7], inquiries into custodial deaths often give the impression that, providing proper rules and guidelines have been followed and the due processes observed, then individual officers can be exempted from criticism. Yet the prisoner has still suffered or died. Surely prison care staff should be encouraged to vary the procedure to benefit the prisoner, at least as often as they appear to ignore it.

This emphasis on process emerges from the paper presented by Mike Longfield, Director of Prison Health Care in England and Wales (Chap 5). He fully documents the codes of conduct, statutory frameworks and ethical codes in which health care is provided in British prisons. There can be little doubt that if the key principles and strategic aims of the prison health care service are fully implemented, there will be little possibility of inhumane care within the prison system. Yet nagging doubts remain. Prisons are penal institutions, not health institutions. They are subject to political direction, which in turn is responsive to perceived public attitudes. Health care professionals are unlikely to be able to overcome other priorities within the prison system, however strong the statutory framework, or however ethical is the behaviour of health care professionals. It was encouraging to learn, for example, that the prison health care service is actively promoting health within the prison system and that the World Health Organisation has expressed its support for the initiative. Participants at the conference however were appalled to learn the level of the present daily food allowance for prisoners. The days when prisoners were not given sufficient food calories in their diets to meet minimum requirements, because of public misconceptions about prisoners being provided with luxurious fare, may be long gone. Nevertheless, it was inherently difficult to envisage how a genuinely healthy diet could be provided for the sums quoted. As

Joe Sim, quoting Ignatieff, said, history 'legitimises the abuses of the present and [adjusts us] to the cruelties of the future'[8].

One vexed question concerns the role of doctors in punishment. This can either take the form of certifying the patient as fit for punishment, or alternatively exempting the prisoner from it. Thomas Percival[9], who led the modern revival of medical ethics in 1803, was in no doubt that a doctor should be present when a prisoner was being flogged. This seems to fly in the face of the modern approach by the British Medical Association[10]. Yet Percival makes it clear that the primary purpose of attendance is for the doctor to observe the man inflicting the punishment, rather than the victim. Army regulations required that the prisoner was not flogged excessively, or with gratuitous cruelty. The doctor's role was not to stop or reduce the punishment, but to ensure that legal powers were not exceeded in each individual case. Despite the ethical dilemmas it will inevitably present to individual prison doctors, such an approach relates to the role of doctors within the British prison system at the present time.

One aspect of this concept of processing individuals, which plays such an important role in prison care and which carries within it the potential for abuse, concerns social changes which themselves require changes in procedure. Jim Beckford (Chap 4) provides an interesting case study on the provision for religious practice in prisons. Although faiths other than Christian ones are relatively over-represented in the prison population, no explicit provision is made in prison rules for religious practices, other than Christian ones. Some governors encourage clerics from other faiths to visit individuals in their prisons, but such clerics do not enjoy the same rights and status as those of Anglican chaplains, upon whom formal responsibility rests. The system is haphazard and hardly

tailored to individual needs. If an holistic approach is taken to health, then spiritual support is as essential as medical support, not least when the faith is practised in a potentially hostile environment. Forum members were particularly interested to learn of this unanticipated problem.

The conference provided a valuable insight into the historical antecedents of prison health care and its underlying subtext of 'less eligibility'. Readers are now invited to examine the papers and the discussion. Much remains to be done to ensure that our prisons provide humane care and do not provide a distant echo of the horrors now associated with the Holocaust.[11]

References

1. Moran M & Wood B. (1993) *States, Regulation & The Medical Profession.* Buckingham: Open University Press.
2. See pp. 8-12.
3. See p. 22ff, 30.
4. Porter R. (1997) *The Greatest Benefit to Mankind* London: HarperCollins: 196
5. Macfarlane A. (1970) *Witchcraft in Tudor and Stuart England.* London: Routledge & Kegan Paul.
6. See p. 27-28.
7. See p. 25, 26-9.
8. See p. 17.
9. Percival T. (1803) *Medical Ethics; or a code of institutes and precepts adapted to the professional conduct of physicians and surgeons.* London: J. Johnson
10. British Medical Association. (1992) *Medicine Betrayed.* London: Zed Books.
11. Inevitably some changes have taken place since these proceedings were recorded. One, for example, is the setting up of the Body Belt Research Steering Group within the prison service.

2. PRISON HEALTH CARE AND THE LESSONS OF HISTORY

Joe Sim

In the concluding paper to a conference on the health of prisoners held in March 1993, Stephen Shaw, the Director of the Prison Reform Trust, cited the German philosopher Georg Hegel, who wrote: 'the lesson of history is that people and governments never learn the lessons of history'[1]. In studying prisons in general this remark is highly pertinent. In the last two hundred years prisons have become the dominant presence on the landscape of punishment in Western Europe and North America. At the same time, the institution has been persistently criticised for its failings.

These failings have included the following points:

- prisons do not diminish the crime rate
- detention causes recidivism
- prisons produce delinquents
- prisons encourage the organisation of a delinquent milieu
- ex-prisoners are condemned to recidivism, because of their living conditions
- and prisons produce delinquency indirectly by 'throwing the inmate's family into destitution'[2].

These critiques, cited by the French philosopher Michel Foucault, sound very familiar to our contemporary ears, yet they were made by different writers between 1820 and 1845. For over 170 years, therefore, the same critiques have been mounted against the prison and yet the institution remains central to the strategies of law and order pursued by various governments here and abroad. Indeed,

not only has the institution become pivotal to these strategies in the last two centuries, but in recent times it has followed a relentlessly expansionist course. By the financial year 1999-2000, the Home Office estimates that the average daily population in England and Wales will be 66,150 (almost certainly this is an underestimation), while the system will be costing over £1.8 billion to maintain[3].

This is not a conference on general developments in penal trends and policy, but I think it is important to recognise that the seemingly never ending critiques of prisons that we hear today not only provide a graphic illustration of Hegel's point that I mentioned earlier, but also provide the wider context for a discussion of prison medicine. I shall return to this point in the concluding section of this paper. For the moment, I want to turn to the question of prison medicine itself.

It is often easy to see the development of health care inside (and outside) prisons as a journey from barbarism to enlightenment. Within this discourse, medical science is understood as a benevolent set of practices, orientated to the psychological and physical well-being of the individual. Indeed, until the turn of this decade, at least in academic and medical circles, this was the dominant view of medical care in prison. Since 1990, a more complex, nuanced and indeed critical analysis has emerged which, in many ways, has run parallel to the critique of the role of medicine in general that has come from a wide range of individuals and groups, particularly women's groups. This more nuanced, critical analysis has challenged the discourse of benevolent development and benign intervention and has instead attempted to study what the organisers of this conference have called the 'historical antecedents' of prison medicine, with a view to understanding 'the continuing

relevance' of these antecedents 'for practice in the broad field of health'.

One important consequence of studying these antecedents is that it allows us to see and identify important historical continuities in relation to the concerns that have been expressed about prison medicine in the last two hundred years. Let me illustrate this through exploring a number of concrete issues.

1. Ill-Health and the Prisoner

Stephen Shaw has pointed out that prisoners have always been a very vulnerable group, experiencing extremely high sickness rates[4]. This issue has a long history. For example in January 1810, there were 700 sick prisoners in Dartmoor prison hospital. In 1822, out of 600 prisoners in Illchester prison, 400 were ill. At an inquest into the death of James Bryant, the jury heard that the gaol had been flooded six times in as many weeks. Parliamentary reports from the time indicated that:

> there was no room in which the deceased could sit with a fire in it during his illness that was not at least six inches deep of water. The jury upon hearing the evidence declared that the deceased had died by the visitation of God, but added, that the event had been accelerated by the damp state of the prison[s]

Nearly two hundred years later, the role of the prison as a generator of physical and psychological ill-health continues to be a source of controversy. Indeed, the idea that there is such a thing as a 'healthy prison' (a term which has become a central part of official discourse in the 1990s) is not only challenged by the historical evidence, but as Smith[6] has pointed

out, is itself a contradiction in terms. I shall come back to this point at the end.

2. The Prisoner as Malingerer

From its earliest days, prison medicine has been concerned with malingering, or shamming as it was known in the nineteenth century. In 1811 Hester Harding was admitted to the infirmary in Gloucester prison. When cured of a sore throat:

> she affected insanity and had to be strapped down. She was given a cold bath with a little hot water added as it was December. It had little affect on her and a straight-jacket was tried and this succeeded. But when faced with Martha Jeynes' insanity, an electric shock was tried instead which the surgeon noted, 'I am pleased to say produced an immediate desired effect, she fell on her knees, confessed and promised to conduct herself properly in the future'. The Electric 'Machine' was used again when she became obstinate, but without effect so the surgeon directed the Turnkey to drench her with 'Beer Caudle' and this proved effective. She was serving two months for stealing butter. The electric shock treatment was not tried again, but the cold bath was used twice more in 1816.[7]

Although, published nearly two hundred years later, John Reed and Maggie Lyne's recent review of prison health care contained chillingly familiar sentiments which resonated with the events at Gloucester. These sentiments were expressed by an NHS general practitioner who, as a sessional worker in prison, said of mentally disturbed prisoners: 'one or two nights in the special [unfurnished] rooms tends to bring them to their senses.' A nurse in charge of a

ward indicated that: 'What they [young prisoners] respond to best is a good shouting at.'

Finally, Reed and Lyne found one doctor who had sanctioned the 'nursing' of a suicidal patient, naked, in an unfurnished room (strip cell) in the spring of 1997[8].

Reed and Lyne concluded that in the nineteen prisons they studied:

> the quality of health care varied greatly. A few prisons provided health care broadly equivalent to NHS care, but in many the health care was of low quality, some doctors were not adequately trained to do the work they faced and some care failed to meet proper ethical standards. Little professional support was available to health care stafP.

3. Less Eligibility and Prisoners' Health

Reed and Lyne's point about the quality of health care echoes another depressingly familiar historical theme. This relates to the fact that the standard of health care for the confined has always been set at a level lower than that experienced by those outside of the prison walls. Historically this doctrine of 'less eligibility' - the assumed requirement that in no circumstances should prisoners be treated more favourably than law abiding members of the community[10] - has had a major impact on prison regimes and, by extension, the health of the confined. Throughout the nineteenth century there were numerous debates concerning the correct level of diet that was necessary in order to generate individual and collective deterrence in relation to criminal behaviour. Hunger prevailed. This in turn led not only to high mortality rates, but also to prisoners supplementing their food with beetles, railway

grease, brown paper, earth, candles, poultice, snails, slugs, frogs and earth-worms[11]. Some doctors, then as now, resisted the demand for regimes to be harsh and degrading. Others, however, put their full professional and ideological weight behind the demand for punitive discipline and engaged in what Dr Edward Smith described in 1864 as "experimental researches" into the prison diet[12]. As Philip Priestley has noted, mid-Victorian prison medicine, despite the humanity shown by some doctors, was nonetheless compromised by its

> appointment to fundamentally disciplinary tasks. The doctors patrolled the narrow straits that separate hunger from starvation and punishment from outright cruelty, hauling aboard the life raft of their dispensations this drowning soul or that and repelling with brute force if necessary the efforts of the others to climb to safety. In so doing, they lent to the work of preserving their employers' reputations whatever dignity and authority their emerging profession possessed - and lost it[13].

4. Medicine, Power and Management

Priestley's comments highlight a fourth historical antecedent in relation to prison medicine, namely the relationship between prison medical personnel and the management of the institutions within which they worked (and continue to work). There are numerous examples which can be identified, both in the nineteenth and twentieth centuries, where prison health workers have been concerned with caring for the order of the prison, rather than ordering the care of the prisoner. The former prison medical officer, John Campbell, published his autobiography in 1884 after serving as an M.O. for thirty years. He noted that:

> Although I am in favour of a mild and encouraging system, with a view to the improvement of the moral and physical condition of convicts, I also desire to see the strictest discipline carried out, so as to suppress any tendency to insubordination or disobedience to prison rules[14].

Identifying with the management of prisons continued to be a major source of controversy through the twentieth century, particularly with the appearance of psychotropic drugs in the 1950s. The medicalisation of often normal behaviour that resulted from this development impacted particularly in women's prisons, where intrusive and controversial management strategies were utilised to regulate the behaviour of the confined[15]. As Stephen Shaw pointed out in March 1993, when overviewing the set of papers arising from a conference on prisoners' health:

> Perhaps the most significant continuing theme emerging from these essays has been concern about the dual responsibilities of prison medical officers to prison management and to their prisoner - patients .... This embrace between medicine and discipline in prisons reached its nadir in the medicalising of control through the use of drugs in the 1960s and 1970s ... . The critical issue is about the self-identification of prison doctors as either personal physicians or as key members of the management of the institution to which they are attached[16].

Learning Lessons

What the last two hundred years has taught us is that prisons have become indispensable to the law and order discourses articulated

by successive governments. As I noted at the beginning of this paper, the penal system in England and Wales (and in most other Western European and North American states) is on a relentlessly expansionist course. That expansion, however, is unlikely to lead to a concomitant expansion of services for prisoners, including health services. Indeed, one of the lessons of the last two centuries is that services for prisoners are usually the first to go during law and order campaigns and the **last** to be developed when crime is not at the top of the political agenda. This is well illustrated in the *Audit of Prison Service Resources* published in July 1997, which indicated that lack of funding in combination with overcrowding is likely to result in: a fall in the level of purposeful activity for prisoners; the disruption to treatment programmes; and the roll-out of drug treatment programmes which were being piloted in *59* prisons[17]. The physical and psychological impact of these developments is obvious.

John Reed and Maggie Lyne identified similar problems in their recent research. For example, while all of the prisons in their study had a commitment to continuing personal development for doctors and nurses, all except one reported a serious shortage of money to fund such programmes. Furthermore, health care budgets were decided on the basis of the previous year's budget, which took into account planned changes and "a reducing overall prison budget"[18].

It is, therefore, important to realise that prisoners' health care needs, as they always have been, are likely to be subservient to the broader goals and agendas set by politicians and governments, while simultaneously being undermined by the continuing emphasis on the prisoner as the less eligible other, who needs to be punished rather than supported. Will integration into the NHS

overturn the experience of the last two hundred years and put prison medical care on a new footing?

While I would support the principle of this move, I am not convinced that it will be the panacea which many reports have suggested. I say this for a number of reasons. First, in its current financial state the NHS is unlikely to welcome an influx of new patients, who are not only regarded as costly, but also as problematic.

Second, many of the recent problems experienced by prisoners have come from doctors already working in the NHS. This issue raises significant questions about how the broader medical profession (and the society in general) perceive and respond to the confined. The lingering ideology of less eligibility, which has been transformed into the late twentieth century discourse of austerity[19], means that many, though not all professionals, still regard those whom we confine as the 'other' - different, abnormal and potentially dangerous. Their incarceration is therefore justified not only as punishment, but also **for** punishment. Changing these discourses which have been laid down over the past two centuries goes well beyond the integration of prison health care services into the NHS.

Third, integration will not only reinforce the mistaken view that penal institutions can deal with the myriad of social problems that exist in this society, but it will also give ideological sustenance to the idea of the healthy prison, which as I noted above, is a contradiction in terms. In addition, it will do little to challenge prevailing policies around, for example, health promotion in prison, which, as Kate Smith has pointed out, is highly problematic when applied to the prison context. In her view health promotion:

> has the potential to create or exacerbate several undesirable outcomes including: the (re(allocation of scarce resources to a relentless search for Risk Factors'; .... and an approach to health and illness which fosters victim blaming and stigmatisation and which ignores socio-economic and environmental issues which have major impacts on health. Illness becomes **symptomatic** of an unhealthy 'lifestyle' and is, therefore, the fault of the individual: the 'wages of sin' described in the statistical language of 'Risk Factors'(emphasis in the original).[20]

The issue of prison food provides a good illustration of the above points. While current prison policy emphasises health promotion and healthy living, in November 1997, the daily food cost allowance per prisoner per day was set at between £1.37 and £1.405, depending on the size of the prison[21]. How is it possible to discuss a healthy lifestyle in a situation in which the basic requirements for physical (and psychological) health, such as food, remain so low on the ladder of prison expenditure? Within the health promotion discourse such broader patterns of expenditure are ignored (as they were in the nineteenth century) in the search for causal factors in the individual's lifestyle which are seen to be at the root of his/her ill-health. Thus, simply concentrating on 'the individual's responsibility for his or her health denies the impact of the wider environment and reinforces individual, rather than collective, responses to social issues'[22].

Future Prospects

So what is to be done? I would argue, as I did in the annual Perrie Lecture in 1993, that in order to challenge and overturn the thrust and direction of the last two hundred years and to point the way

forward for prison health care, a number of strategies need to be pursued[23].

First, there needs to be a huge reduction in the prison population, together with the development of a range of alternative centres for the treatment of, for example, drug dependency. Prisons should therefore, 'become places of last resort, not the first step on what often proves to be a grim institutional journey' for a number of different, often powerless, groups[24].

Second, there needs to be a radical redistribution of resources within prisons and the criminal justice system in general. Extra resources is not the issue, it is how money is spent that is the key question. Does our society really need another six prisons, when alternative therapeutic programmes inside, and places like rape crises centres outside the walls are desperately struggling for resources to maintain their services?

Third, the philosophy, strategies and programmes developed in institutions such as Grendon Underwood, Parkhurst 'C Wing and the Barlinnie Special Unit[25], should become central to future penal policy. Why has this not happened? The answer lies in understanding the history of prisons and in recognising that these institutions have been built on what Giles Playfair called 'the punitive obsession'[26]. Challenges to that obsession have either been marginalised, or labelled as 'experiments', aberrations to what the 'real' work of the prison is about, namely discipline and punishment.

Taken together, the implementation of these suggestions offer a blueprint for future penal arrangements for those who need to be confined:

> Confinement needs to take place within a political context in which prisons as places of punishment are decentred and become places of last resort; places which have a series of social, educational and psychotherapeutic programmes which are **not** separated from similar programmes in the wider community, and places which are staffed by individuals who are not regarded as strange and deviant by their colleagues[27] .

It would be nice to think that a similar conference to this one will be held in two hundred years' time and that equivalent speakers will look back and say that the late twentieth century finally broke with tradition and instigated a penal system (and within it a health care system), which was based on very different philosophical discourses from those which dominated the first two hundred years of that system's existence. Alternative visions have existed and do exist within prisons whose guiding principles are care, compassion and empathy. The support given by some prison medical workers who choose to work with prisoners who are HTV positive is a brilliant contemporary example of this. Those voices and experiences are likely, however, to remain on the margins (as they always have been historically) unless a major philosophical and political shift in attitudes towards crime and punishment takes place. In its own way history can contribute to that shift for, as Michael Ignatieff reminds us:

> [history] can help to pierce through the rhetoric that ceaselessly presents the further consolidation of carceral power as a 'reform'. As much as anything else, it is this suffocating vision of the past that legitimizes the abuses of the present and seeks to adjust us to the cruelties of the future.[28]

Refusing to accept the inevitability of these future cruelties through recognising the impact of medical power in prisons over the last two centuries would be a positive legacy, both for the confined and the non-confined.

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3. HUMAN VALUES AND DEATHS IN DETENTION

Tony Ward and Deborah Coles

> [I]mprisonment is as irrevocable as hanging. Each is a method of taking a criminal's life; and when he prefers hanging or suicide to imprisonment for life, as he sometimes does, he says, in effect, that he would rather you took his life all at once, painlessly, than minute by minute in long-drawn-out torture.
>
> **George Bernard Shaw.**[1]

Shaw's apparently compassionate remarks form part of an argument for using the 'lethal chamber' to dispose of a wide range of 'incurable and pathological case[s] of crime'. The use of gas-chambers and other 'humane' methods of killing, not as a punishment but a means of disposing of the 'incurably' deviant, had a considerable appeal in the early twentieth century among - as the Medical Superintendent of Broadmoor put it - 'those who like to think of themselves as especially strong-minded'[2]. Prominent among the 'strong-minded' were the leading forensic pathologist F.J. Smith, who proposed that a gas chamber - disguised as an ordinary cell - be installed in Broadmoor[3]; H.G. Wells, in whose New Republic criminal lunatics (among others) would be put down with opiates[4]; and the Marxist biologist Joseph Needham, who wrote that 'Scientifically speaking, there can be no such thing as personal responsibility, and all that can be done is to disembarrass society of its undesirable elements by killing them off'[5]. Such views did not command wide support among the medical profession; but as Joe Sim has pointed out, doctors, including prison doctors, were prominent in the eugenics movement and in urging that segregation of the 'weak-minded'[6] was necessary 'from the point of view of improvement of the race'[7].

These historical remarks are prompted by the question which inspired the setting up of the Human Values in Health Care Forum: could the perversion of medicine under the Nazis have happened here? But are they relevant to the subject on which we were invited to address the Forum: that of deaths in detention in Britain today? We believe there is a connection, albeit at a rather abstract level. If we take seriously Zygmunt Bauman's disturbing insight that the Nazi genocide was not an expression of irrational evil, but rather an extreme manifestation of tendencies inherent in the modern, rational, bureaucratic state[8]and Michel Foucault's analysis of the prison as the epitome of modern, 'scientific' disciplinary power[9], then the Holocaust can be seen as representing, in a greatly intensified form, a kind of inhumanity which is ingrained in the prison system and many other institutions of the modern state. The eighteenth century enlightenment, which gave us the Kantian respect for the dignity and autonomy of each human being that is the cornerstone of 'human values', also gave us the modern prison; and the same aspect of modernity which gave us the modern prison gave us the 'strong-minded' attitude to human life of much of the early twentieth century intelligentsia that ultimately brought us the holocaust. We wish to suggest that there is something about the prison - and about criminal justice in general - which is deeply inimical to 'human values' and which is revealed in the circumstances surrounding some deaths in custody. In making this general point we do not at all seek to deprecate the efforts of those individuals working within the criminal justice system, whose careers have been dedicated to what Andrew Rutherford calls 'the pursuit of decency'.[10] On the contrary, they are all the more to be admired for struggling against tendencies which are so deeply ingrained in the system in which they work.

A Death in Prison

Let us now descend from this abstract level of discussion and describe one, not atypical, prison death: that of Kenneth Severin in Belmarsh prison on 25th November 1995. He was a 25 year old African Caribbean man with serious mental health problems and had been remanded in custody on a charge of attempted burglary. He was homeless, his council flat having been burnt out and vandalized, and was arrested in the small hours of the morning while attempting to break into a house where he had previously lived. He was known to his local mental health team and had in the past been diagnosed as suffering from paranoid schizophrenia.

On his arrest Mr Severin was taken to Greenwich Police Station. The police realised he was mentally ill and contacted his community psychiatric nurse, but the nurse did not tell the police about the diagnosis of schizophrenia. When he appeared at Greenwich Magistrates' Court no bail application was made, on the grounds that little was known about him and there was nowhere for him to go. He was remanded to Belmarsh for a week. On his second appearance in court the duty psychiatrist had to leave early and was unable to see him. This time a bail application was made, but refused. Another week passed; the psychiatrist saw him and found him fit to plead; bail was again applied for and refused.

On his initial reception into Belmarsh on 1st November 1995, Mr Severin was interviewed by a prison doctor and located in the health care centre because of his mental health problems. The evidence at the inquest suggested that one aspect of the 'health care' he received was the treatment of bizarre or disruptive behaviour as a disciplinary problem, rather than a medical issue. He was subject to two disciplinary adjudications: one for refusing

to move his cup, etc. from the observation hatch when ordered to do so and one for being abusive to a prison officer, by saying 'Stop switching off my light you arsehole'. Although he was identified as a paranoid schizophrenic, a prison medical officer assessed him as fit for adjudication and cellular confinement.

At night in the health care centre, in addition to the discipline staff, there were two staff members with mental nursing qualifications on duty and a doctor was available on call. Nurse Ward had some contact with Mr Severin shortly before midnight, when he asked for some cakes and sugar, which she gave him. She had had no contact before and did not know he was diagnosed as schizophrenic. She said that nothing about his behaviour gave her any cause for concern. About an hour and a half later she was asked by the senior health care worker to go and see Mr Severin. She was not told why, nor did the health care worker consider it relevant to give her any information about Mr Severin's medical history of mental illness. Nurse Ward did not look at his medical records. When she saw him again she noticed a marked change in his manner; he was hostile and shouting. She managed to calm him down, and had no concern that he was at risk of harming himself.

Principal Officer Benson was the most senior officer in the prison that night and was effectively in charge. At about 12.55a.m. he was contacted by officers on duty in the hospital wing, who said that Mr Severin was causing a disturbance by shouting and banging on his door. PO Benson and three other officers went to the health centre where they were told that Mr Severin had been agitated since 10.00p.m. (Medical records confirm that he had been agitated for at least this length of time, but nursing staff were not aware of the fact.). PO Benson saw him in his cell. He was

shouting 'I shouldn't be here!', 'See the judge!', 'Let me go home!' and other things which PO Benson described as incoherent. PO Benson accepted that this behaviour was bizarre, but he knew nothing about Mr Severin and did not seek any information from medical staff. He did not consider it appropriate that there should be any medical input into the decision he now took to put Mr Severin in strip conditions, although official guidelines stress that such input is necessary.

All the prison officers who testified at the inquest insisted that the strip cells were never used as punishment and justified their decision to locate Mr Severin there by his potential to harm himself.[n]At no time had any medical or discipline staff considered him to be a suicide risk.

It is unclear whether anyone explained to Mr Severin that he was being moved to a strip cell, but a struggle started when he was told he could not take his Walkman with him. It took five officers to restrain him, using techniques known as 'Control and Restraint'. With his hands in ratchet cuffs behind his back, he was taken, still struggling, via a lift to a strip cell on the upper floor of the health care centre. Seven officers took part in restraining him in the cell. He was placed, still handcuffed, face down on a mattress. He was totally stripped from the waist down, then his handcuffs were removed, followed by the rest of his clothes.

Prison regulations state: 'A prisoner may be deprived of normal clothes only if, in the light of the individual case, this is considered essential to prevent self injury or injury to others.'[12] Prison officers, however, said it was standard practice to strip any prisoner going to a strip cell. They could point to nothing in any official rule or guideline to justify this practice.

Prison officers checked Mr Severin's pulse. They were concerned at how still he had become, so they checked it again. It was apparently normal. They left the cell and called a senior nurse, who found Mr Severin naked, lying on his stomach, his hands in the same position they would have been in when the cuffs were removed. An ambulance was called but all attempts at resuscitation failed.

All the officers involved in the control and restraint denied that they had used excessive force, or applied a neckhold, or any pressure on the back. They were unable to explain the deep bruising over the back found at two post mortems. None of the officers who gave evidence had received any training on the potential dangers of control and restraint and in particular of placing someone face down with their hands cuffed behind their back. Even the officer responsible for control and restraint training had never heard of positional asphyxia before the day of the inquest and was not sure why placing a prisoner in such a position might be dangerous. Although a Circular Instruction issued after the death of another prisoner[13] in the course of control and restraint dealt with this issue, and formed part of the control and restraint manual, none of the officers, nor even the trainer, was aware of it. They claimed to have followed the guidelines on control and restraint to the letter. All those involved in restraining Mr Severin referred to his 'superhuman' and 'incredible' strength.

The pathologist who carried out the post mortem on behalf of the coroner considered that the deep bruising on the back was probably caused by pressure, rather than by blows or kicks. There was also some bruising to the neck. He was satisfied that death was due to asphyxia, as a result of the position in which Mr

Severin was restrained, combined with pressure being exerted on the back. Drugs or alcohol did not contribute to the death. A pathologist instructed by the family agreed with these conclusions. A third pathologist who reviewed the post-mortem reports on behalf of the prison service agreed that positional asphyxia was the most likely cause (though he thought some more unusual causes could not be excluded), but considered that the bruising on the neck was probably due to muscle tearing during a struggle.

The jury at the inquest was left with a choice of three verdicts: unlawful killing, which required proof beyond reasonable doubt; accidental death, which could be proved on the balance of probabilities; or an open verdict. By a majority of nine to two they concluded that the cause of death was positional asphyxia following struggle and restraint during relocation and returned an open verdict. The coroner made seven very strong recommendations and commented on the 'appalling state of affairs' surrounding the case.

A Terrifying Contraption

Let us briefly enumerate some of the truly appalling features of this state of affairs and consider how they relate to our opening remarks. First, there is the overwhelming preoccupation with discipline, rather than health - with, as Foucault would put it, the disciplined body, rather than the healthy body, which as Joe Sim's chapter suggests has been a constant theme in the history of prison health care.

Then there is the chilling explanation of why the officers stripped Mr Severin naked: it was 'standard practice'. Mr Severin was treated as he was, not (apparently) out of anger or hatred or sadism, nor out of any particular belief that it was the right thing

to do, but because those involved believed (wrongly) that they were correctly playing out their roles in the institution.

Nobody, in the various institutions through whose hands he passed, **knew** Kenneth Severin. A fair amount was known **about** him - knowledge existed in various files - but no-one saw the whole picture. Mr Severin appeared as a member of various diagnostic, legal and disciplinary categories; never as a whole person.

And no-one, it seems, was responsible for his death. The difficulty in assigning moral responsibility is epitomized in the jury's open verdict. The jury were not willing to categorise his death as an accident, but neither were they satisfied that it was an 'unlawful killing'; a verdict which requires some individual (who cannot be named) to be judged criminally responsible. In part, this reflects the fact that nearly all the evidence about the fatal incident came from the prison officers themselves, and the jury's task was complicated by a difference of opinion between forensic pathologists. But in any case, how fair would it have been to hold any individual officer responsible? Or the doctor? The community psychiatric nurse? The magistrates? Government ministers? And if any individual **were** held responsible, it could only be on the basis that they were not in fact following "standard practice". As Laws J said recently, in a case arising out of another death from positional asphyxia, this time during an arrest by police, it is 'unreal' to suppose that a jury could find an unlawful killing verdict where police officers had acted 'in accordance with current police methods'.[14]

What we see in the 'standard practice' of a disciplinary institution is the working of what, according to Bauman, made the Nazi death camps possible: 'that curious and terrifying socially invented modern contraption which permits the separation of action and

ethics, of what people do from what people feel or believe, or the nature of the collective deed from the motives of individual actors'[15]. Kenneth Severin's death was not an act of malice by one individual against another: it was the 'standard practice' of an institution against an anonymous, refractory body. It is perhaps also significant that this was a **black** body, endowed with the 'superhuman strength' which has been attributed to a number of such bodies at inquests on deaths in custody[16].

A Death in Police Custody

The same difficulty of assigning individual responsibility for deaths in the hands of institutions arises where people die in police cells. Although some deaths in police custody arise from forms of restraints similar to that used on Kenneth Severin, much the commonest type of death is that which occurs when someone is arrested for drunkenness and dies, either from some cause related to their drinking, or from an unrelated illness or injury, the effects of which are masked by, or mistaken for, drunkenness.

One such death was that of John Leo O'Reilly, aged 63. He was arrested for being drunk and incapable on 2 July 1994 and taken to Little Park St. Police Station in Coventry. After some 13 hours in detention he was taken to hospital. He was described by one of the ambulance crew who took him as 'deeply unconscious - semi dressed, shaking and lying in a pool of urine and vomit - his hair was matted with sick'. This evidence is difficult to reconcile with that of the police who told the inquest Mr O'Reilly had been sitting up in his cell and cracking jokes. On arrival at hospital he was found to have a fractured skull. He died two weeks later.

In December 1997 the Police Complaints Authority (PCA) decided that three West Midlands Police officers should be warned, and

one admonished, for failing to follow Force guidelines. The PCA justified this lenient decision by saying that, even if Mr O'Reilly had been taken to hospital in time, he would not have recovered. Yet the medical evidence at the two inquests on Mr O'Reilly (the first was quashed by the High Court) was to the effect that it was impossible to say whether he would have recovered, had he been taken to hospital promptly.

A statement by the O'Reilly family expresses their outrage at the Police Complaints Authority's attitude: 'These officers allowed Mr O'Reilly's condition and environment to degenerate below what is acceptable in a democratic society and those officers should be held accountable for their actions.... The [Authority] has allowed itself to become an apologist for police malpractice and cannot expect to enjoy public confidence'.[17]

Scapegoating

But there is another side to the argument over the accountability of individual officers, which is put in a recent article in *Police Review* by Dr Hugh de la Haye Davies[18]. Dr Davies is a retired police surgeon and past President of the Association of Police Surgeons, but he writes from a viewpoint strongly sympathetic to the rank-and-file police officers involved in the case of Jack Cunningham. The case is very similar to John O'Reilly's, with two important differences. One is that Mr Cunningham did not die, but was left permanently disabled. The other is that the Northamptonshire Police imposed relatively serious disciplinary measures (relative, that is, to the lack of action in most such cases) on the five custody sergeants involved in the case, who pleaded guilty to 11 charges of disobedience to orders, neglect of duty, and falsification or prevarication in relation to custody records. All were cautioned and five received fines of up to £300.

Dr Davies' view is that these five officers, who, without adequate training, regularly take on the unpleasant task of caring for people who might otherwise die on the streets, have been made scapegoats for a system which fails to provide proper facilities for people with drug and alcohol problems. Although he considers that the fatal head injury was probably sustained before arrest, he argues that Mr Cunningham's 'abusive and obnoxious' behaviour was 'proof enough that he did not warrant medical examination'. But whatever the merits of Dr Davies' defence of the particular officers, we have some sympathy with his broader argument that disciplinary inquiries get sidetracked into questions about whether correct procedures have been followed. On the one hand, the procedures may offer only limited protection, but they are laid down for a reason and there is a pattern of cases in which officers depart from them with tragic consequences. On the other hand it often seems that the question which preoccupies the coroners' courts is not, 'Did you provide a decent standard of care?' but, 'Did you exercise the required surveillance and keep the required records?'

In Mr Cunningham's case the relevant rule was that drunken prisoners, who are in an insensible state, should be roused and spoken to every half hour. Dr Davies comments:

> [The half-hour waking up rule gives false security. It is Sod's law that the fatal vomit or intracranial bleed will happen five minutes after waking. And it is Murphy's law that, when it is discovered 25 minutes later, the resulting panic will ensure that it is not entered in the custody record accurately and perhaps the contemporaneous notes will not quite satisfy the complaints and discipline department, which is exactly what happened in Northampton.[19]

Does the blame rest, as Dr Davies suggests, with senior officers? No doubt they would be only too happy to see people like Mr Cunningham taken to some kind of detoxification or 'drying out' centre, and would say that the blame lies with endless buck-passing between the Home Office and the Department of Health.

This brings us back to Bauman's 'terrifying contraption'. Bauman's point, and ours, is not that those who work for the state are bad people, but that the bureaucratic apparatus of the modern state has an inherent tendency to produce a moral vacuum at the point where it impinges on individuals' lives. This is not only a feature of criminal justice systems, but it is particularly ironic that criminal justice, which sets such store by individual moral accountability, is so bad at calling its own servants to account. Experiments such as the Barlinnie Special Unit, referred to in Joe Sim's paper, suggest that this is not an absolutely inevitable feature of state institutions but, as Sim's conclusions indicate, to place 'human values' at the centre of criminal justice would require far-reaching change (see pp. 15-17).

Let us end where we began, with George Bernard Shaw, and the essay where he writes so glibly about lethal chambers, which begins: 'Imprisonment as it exists today is a worse crime than any of those committed by its victims; for no single criminal can be as powerful for evil, or as unrestrained in its exercise, as an organised nation.'[20]

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4. PRISON CHAPLAINCY AND PRISONERS' HEALTH CARE AT A TIME OF GROWING RELIGIOUS DIVERSITY

Jim Beckford & Sophie Gilliat-Ray

Introduction

This paper raises more questions than it can answer. The main reason for this is that our research on the pastoral and religious care of prisoners in England and Wales was not directly concerned with health care. Our findings suggest that it would be interesting and helpful to start asking questions about the relation between chaplaincy and health care in prisons. We shall therefore use our knowledge about chaplaincy to identify a range of issues about the health care of prisoners, which seem to be important enough to warrant serious consideration. Our main focus will be on what the Prison Service calls 'other faiths'[1], i.e. Buddhism, Hinduism, Judaism, Islam and Sikhism.

The amount of research on other faiths in British prisons is extremely small[2], although some of the legal challenges mounted by religious minority prisoners in the USA have attracted extensive commentary[3]. There has also been discussion in the USA about the value of prison chaplaincy for Sunni Muslims and for members of the Nation of Islam[4]. Yet, it is significant for our purposes that consideration of religious diversity was entirely absent from two recent discussions of health among prisoners. The first was a wide-ranging review of research on 'Health condition and prisoners', which appeared in *The Prison Journal*[5]. The second was a report of empirical research into 'The quality of health care in prison' which appeared in *The British Medical Journal.* We therefore seek to place the issue of religious diversity firmly on the agenda of policy makers concerned with the mental, physical and spiritual well-being of prisoners.

Our main argument will be that the increase in the number and proportion of prisoners registering as members of religions other than Christianity gives rise to fresh challenges and opportunities for health care professionals and chaplains alike.

As this is relatively uncharted territory, we need to begin by clarifying how our research into other faiths and prisoners was designed and carried out. In the second section of the paper we shall explore the implications of growing religious diversity for a prison system with a Christian chaplaincy service. One of these implications is that Visiting Ministers from non-Christian faiths are marginalised in prisons and therefore less likely than Christian chaplains to be able to contribute towards the spiritual **and** physical well-being of prisoners in their care.

Our research was conducted between 1994 and 1996. It was mainly limited to the prisons of England and Wales, but also included several penal institutions in the United States. We set out to discover two things. The first was how religious and pastoral care was provided for prisoners who registered as members of 'other faiths'. The second was how Church of England chaplains facilitated the provision of this care for staff and prisoners who were not Christians.

We gathered information primarily by means of a questionnaire mailed to all Anglican prison chaplains and by means of interviews with 20 Anglican chaplains working in a wide variety of establishments. In addition, we administered questionnaires to all 'ministers' and representatives of other faiths known to be offering religious and spiritual care to prisoners. We also interviewed 17 of these Visiting Ministers. Additional interviews were conducted with 11 Free Church and 12 Roman Catholic chaplains. Although we spoke to many prisoners in the course of our one-day visits to fourteen establishments, we did not try to ascertain their responses to the religious and pastoral care available to them. There is a pressing need for research on the prisoners' own responses to chaplains and to chaplaincy.

Why did our research into 'other faiths' pay so much attention to the Church of England chaplains in England and Wales? The reason is that, although Anglican chaplains work collaboratively and ecumenically with Catholic and Free Church chaplains in most institutions, there are legal, practical and customary grounds for the Church of England's ascendancy over prison chaplaincy. To summarise briefly, the Prison Act 1952 requires every prison to have a Church of England 'clergyman', whereas the appointment of ministers from other religions or branches of Christianity is at the discretion of Governors; the Prison Rules and other administrative instruments identify Anglican chaplains as the officials who normally deal with members of other faiths; and prison staff, including Governor grades, are accustomed to regarding the Anglican chaplain as 'the' chaplain, even in establishments where there are full-time Catholic or Free Church chaplains.[7] But the brute fact of numerical superiority probably accounts for most of the ascendancy that Anglican chaplains enjoy over chaplaincy.

Table 1: Prison chaplains, England and Wales, 1997[8]

	Full-Time				**Part-Time**				
	Male	Female	All	(%)	Male	Female	All	(%)	Total
Church of England	86	18	104	(79)	83	28	111	(32)	215
Roman Catholic Church	20	7	27	(20)	115	0	115	(33)	142
Churches	*X*	0	1	(1)	107	15	122	(35)	123
Total	**107**	**25**	**132**	**(100)**	**305**	**43**	**348**	**(100)**	**480**

Table 1 illustrates the numerical dominance of Anglican chaplains among the Christian chaplains.

Our research showed that it was common for Anglican chaplains to take administrative responsibility for chaplaincy and, in particular, to deal with matters concerning other faith communities, largely because they were more likely than other chaplains to be on duty frequently enough and long enough to provide administrative know-how and continuity.

Another reason for the dominant position of Anglicans and other clergy in the Prison Service Chaplaincy, which is responsible for all chaplaincy matters, has to do with its composition. The Chaplain General and the three Assistant Chaplains General are all Anglicans. They work collaboratively with two senior Roman Catholic chaplains and one Superintendent Methodist chaplain, who represents the Free Churches. This headquarters group is officially responsible for all policies relating to the provision of prisoners' religious and pastoral care, **including those who are not Christians.** The Chaplain General conducts a twice-yearly 'consultation' with leading representatives of other faith communities and some minority Christian groups, but no members of non-Christian communities can be appointed as chaplains or, *a fortiori,* serve in the Prison Service Chaplaincy headquarters group.

In short, prison chaplaincy is dominated by Christian clergy, among whom the Church of England chaplains tend to enjoy the most significant authority and responsibility. It does not follow, however, that other faith traditions are excluded from participation in prison chaplaincy. They are merely dependent on the 'brokerage' of Christian, usually Anglican, chaplains, in ways which have implications for health care.

Religious Diversity

Prisoners are permitted to register as members of any one of about forty 'permitted religions', including many branches of Christianity. While there are many reasons for treating the statistics of prisoners' religious registrations with extreme caution[9], three major trends are indisputable. Firstly, the proportion of prisoners who choose to register as having no religion, or as being atheists and agnostics has increased by about 25 per cent in the last twenty years. Secondly, the proportion of prisoners who register as members of Christian churches has declined steadily. And thirdly, the proportion of the prison population coming from the Buddhist, Hindu, Muslim and Sikh faith traditions has been increasing slowly for many years. As Table 2 shows, however, most of this growth has been among Muslims. In fact, they accounted for 86 per cent of the increase in 'other faith' registrations between 1991 and 1997. By contrast, the number of Jewish prisoners has been virtually static for a long time.

Members of other faiths amounted to just over 11 per cent of all prisoners who chose to register as members of any religious group in 1997, thereby exceeding by a large margin their proportion in the British population. So, although these prisoners are still in the minority, they nevertheless represent a significant and growing proportion of inmates. Moreover, we know from other studies[10] that, with the exception of most Buddhists, members of 'other faiths' in the UK are also likely to come from ethnic minority communities and, therefore, to be susceptible to a wide range of deprivation and discrimination. Levy's description of prisoners in many countries is applicable to those in England and Wales:

Table 2: Religious registrations, 1975-1997, H.M. Prisons, England and Wales[11]

	1975	%	1997	%	Change in percentage 1975/97	Ratio of 1997 % t« 1975 %
Main Christian	30,974	94.0	36,498	63.0	-31.0	0.67
Other Christian	240	0.7	527	0.9	+0.2	1.28
Main Other Faiths:						
Buddhist			226			
Hindu			198			
Jewish	273		288			
Muslim	529		3,693			
Sikh	310		394			
Sub-total	1,112	3.3	4,799	8.3	+5.0	2.51
Other Faiths:			203	0.3		
Agnostic, Atheist None	649	2.0	15,840	27.3	+25.3	13.65
Non-permitted Religions[1]			138	0.2		
Total	32,975	100	58,005	100	+75.9	

> Prisoners are far from being representative of the general population. They are predominantly male, young (15-44 years), and poorly educated and belong to minority or migrant groups. Many have lived on the margins of the community, and there they are likely to return. This complex of factors ensures the greatest chance of ill health, optimal conditions for infection to progress to severe disease, and minimal opportunity for early diagnosis and adequate treatment.[13]

It would be reasonable to infer, then, that prisoners who belong to other faiths might, on average, be in more need than most other prisoners of religious and pastoral care. This is partly why we tried to discover how the Church of England's ascendancy over prison chaplaincy affected non-Christian prisoners' access to such care. The Prison Service Chaplaincy, staffed entirely by Christian clergy, professes a mission to all prisoners, regardless of their religious identity or sympathy. Furthermore, we collected impressive evidence about the willingness of many individual chaplains to facilitate the religious practices of prisoners belonging to other faith communities. We wanted to know how well this facilitation worked in practice.

Visiting Ministers

Prisoners who register as members of other faith communities should, according to Prison Service policies, be permitted to practise their religion and to have the same opportunities for doing so as those enjoyed by prisoners from Christian backgrounds, as far as is practicable in prison conditions. Yet, no ministers of other faiths are permitted to be called 'chaplains': they are officially known as Visiting Ministers. None of them is employed by the Prison Service. And only a few of them can afford to work full-time as Visiting Ministers. As a result, they tend to visit their

prisoners at best once a week for two hours or, more commonly, once every few weeks.

Most Visiting Ministers have their travel expenses reimbursed by the establishments that they are appointed to visit; and some also receive hourly fees for their work. Not surprisingly, there are allegations that some Governors have tried to reduce these payments, thereby limiting the prisoners' opportunities to practise their religion. Church of England chaplains sometimes find themselves caught in the cross-fire between budget conscious Governors and members of other faiths, who feel aggrieved that their opportunities to practise their religion are unfairly restricted by financial considerations.

Similar problems arise in connection with the facilities provided for prisoners and Visiting Members of other faiths. This is not the place to review all our evidence, but it is enough to report that we found high levels of dissatisfaction with the quality of meeting rooms, religious artefacts, diets and arrangements for celebrating major religious festivals among about one third of Visiting Ministers. No training had been offered to Visiting Ministers until the Spring of 1997; and administrative support is still not provided for any of them. It is unusual for Visiting Ministers officially to be included in 'chaplaincy teams' and, as far as we know, extremely rare for Visiting Ministers to represent chaplaincy on any prison committees. They are marginal to the social life of chaplaincies, partly because of the brevity of their visits to prisoners. They are also excluded from the administration of chaplaincy policies and procedures.

In other words, we found that prisoners' opportunities for 'equal rites', measured in terms of access to Visiting Ministers and appropriate facilities, did not correspond well with official Prison

Service policies. This is ironic, in view of the three trends that we identified earlier in religious registrations:

(a) the proportion of prisoners who choose to register as members of Christian churches is declining;

(b) the proportion of prisoners who do not register as members of any religious group is increasing sharply;

(c) the proportion of prisoners associated with other faith communities is growing slowly, albeit at different rates in different communities.

Having set the scene we can now begin to tease out the **implications** of these inequalities in religious opportunities for the health care of prisoners from 'other faith' communities.

Chaplaincy and Health Care

It has been necessary to outline the **structures** of prison chaplaincy, so that the relations of dependency of 'other faiths' on the Church of England and other Christian churches could be thrown into sharp relief. We emphasise the word 'structures' because we have no reason to suspect that most **individual** Anglican chaplains do not bend over backwards to facilitate the work of Visiting Ministers. The focus of our analysis is firmly on the administrative and organisational structures within which religious and pastoral care is provided for non-Christian prisoners. We infer that these structures may have the following five implications for the health care of Buddhist, Hindu, Jewish, Muslim and Sikh prisoners.

1. At the risk of sounding naive and idealistic, we think it unlikely that 'whole person' health care could be cultivated among

prisoners whose spiritual advisers and religious teachers have so little personal contact with them, or with their medical doctors. There is little opportunity for Visiting Ministers to spend more than one or two hours each week with, in some establishments, more than twenty participants in collective prayers, meditation or study of religious texts. This is richly ironic, given that much of the philosophical inspiration for ideas of holistic health care has come from the Asian religious traditions, represented by many Visiting Ministers. Many of our Hindu, Muslim and Sikh informants felt frustrated by the structural obstacles in chaplaincies to the development of therapies, which combined religion, spirituality, ethics, diet and health care.

2. A much more down-to-earth consideration is that, in the absence of any chaplains from other faith traditions, the so-called statutory duties can be carried out only by Christians. This means that the daily requirement to conduct reception interviews, to visit prisoners in segregation units and to visit prisoners in health care centres can rarely be fulfilled by Visiting Ministers. Christian chaplains often speak with impressive seriousness about the help that they can offer to prisoners on arrival, undergoing segregation or during illness. We have no reason to doubt that many prisoners benefit significantly from these ministrations. This only makes it all the more regrettable that the structures of chaplaincy do not permit Visiting Ministers to take some responsibility for the conduct of statutory duties. Indeed, we heard complaints from some Visiting Ministers that they had not even been informed about the illness or death of prisoners in their religious care. Perhaps it is significant that not a single Visiting Minister reported to us that they had been in communication with prison health care staff. In so far as there is any communication between health

care and religious professionals, it is almost entirely restricted to Christian chaplains. The question is whether this is acceptable at a time of increasing religious diversity.

3. A third consideration is about training both for Visiting Ministers and for health care staff. The Prison Service Chaplaincy organised the first ever training course for Visiting Ministers in May 1997. Representatives of some, but not all, faith communities had been calling for such training for many years. The course was apparently successful and may become a regular event. Until this year, however, the training of Visiting Ministers had been either non-existent or entirely at the discretion of individual chaplains or Governors. This means that, unlike Anglican chaplains, very few Visiting Ministers were instructed in such things as suicide awareness or techniques for detecting signs of substance abuse, bullying and mental illness. Yet in some respects Visiting Ministers develop the kind of relations with prisoners through which early detection of health-related problems might be possible.

   None of the Visiting Ministers in our study had been asked to help train prison staff to understand the social and cultural customs of their particular faith and/or ethnic communities. This is something that chaplains are occasionally expected to do, and the Prison Service Chaplaincy provides a fairly comprehensive *Directory and Guide on Religious Practices.* Moreover, the *Prison Service Order on Race Relations* contains extensive, detailed guidance on practices intended to ensure that prisoners can practise their religion as freely as possible within the constraints of custody. Yet the expertise of Visiting Ministers is not routinely enlisted for the purpose of discussing with health care staff matters relating to, for example, diet, clothing, family

relationships, spiritual well-being or bereavement. It is usually left to Church of England and other Christian chaplains to act as intermediaries or cultural interpreters between prison authorities and 'other faith' communities. We wonder whether this situation is still acceptable at a time when 'other faith' communities are not only growing in relative and absolute size, but are also producing more and more representatives with the necessary skills and experience to provide suitable training or advice. Some Buddhist Visiting Ministers, for example, are clearly skilled in techniques which have a direct bearing on inter-personal relations and group dynamics.

4. Another issue concerns the collective identity and loyalty which tends to develop among those Muslim inmates in particular who spend a lot time together in study, prayer and in preparations for Eid[14] festivals. The numbers of Muslims have reached the point in some establishments where a genuinely collective concern emerges around some individuals' problems. Visiting Imams are often aware of these shared concerns, but rarely have the time or the expertise to take them up with health care staff or other prison staff. With better training and with a closer integration of Visiting Ministers, in their own right, into the processes of monitoring the well-being of prisoners, it might be possible to prevent some individual and collective difficulties from escalating into crises. In other words, Visiting Ministers are a potentially **valuable resource** for the establishments where they serve, but there has to be a question about how well the current structures of chaplaincy cultivate that resource and enable it to be put to best effect.

   One of the possible objections to the idea that better use might be made of Visiting Ministers of other faiths in looking after the

health of prisoners, is that very few of them have had the benefit of the kind of pastoral training required of Christian chaplains. Indeed, many chaplains claimed that Visiting Ministers were not adequately prepared for any role in prisons beyond the conduct of routine prayers and worship. This claim may or may not be true, but it begs the question why the Prison Service took no steps until the Spring of 1997 to encourage Visiting Ministers to develop the kind of pastoral skills which could be helpful to prisoners, or to offer them appropriate training opportunities.

5. Discussion of the mental health of people from ethnic or religious minorities is fraught with all kinds of difficulties and sensitivities. The scientific literature on this topic is considerable: there is now a specialist journal on *Religion and Mental Health*, and a recent report[15] claimed that manifestations of religious belief among some ethnic minorities are often interpreted by health care workers in East London as symptoms of mental health problems. In the midst of so many different ideas and ideological traps for the unwary, however, at least one thing seems to be agreed:- the boundary between spiritual well-being and mental health is as important as it is contested. Fortunately, the British Government does not share the German Government's opinion that new religious movements represent a 'flight from reality', but mental health professionals are sometimes, and for good reason, unsure about the meaning of disturbed behaviour or distress which might be attributable to 'spiritual' considerations. In these cases, the role of authoritative 'interpreters' and 'go-betweens' from the relevant communities can be helpful. Visiting Ministers are in a position to help, but our research found no evidence that prison health care staff consulted them. This is not surprising, because the current structures of chaplaincy tend to marginalise Visiting Ministers

and to impose on them a rather narrow definition of the roles of religious teachers and priests.

Conclusion

This has been a speculative paper. On the basis of what our research revealed about the structural marginality of 'other faiths' and their Visiting Ministers to prison chaplaincy, we have speculated about the implications of this marginality for the health care of non-Christian prisoners. We conclude with a question. Is it acceptable, at a time of growing religious diversity in this country, for the spiritual and religious care of Buddhist, Hindu, Jewish, Muslim and Sikh prisoners to remain so heavily dependent on the good offices of Christian chaplains? We suggest that this arrangement has undoubtedly worked to the advantage of some prisoners in the past, but that it may have unhelpful implications for the health care of the growing number of prisoners from other faith communities and that further public debate of this issue is now overdue. Whilst we agree with Martin Jacques that 'Britain has the potential to become a new kind of multi-ethnic, multicultural society, a true creature of the global era'[16], this potential will be realised only if ethnic and religious minorities enjoy equal opportunities to participate in mainstream life. Gaining access to prison chaplaincy in their own right is one of those opportunities.

Acknowledgements

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5. PRISON HEALTH CARE IN ENGLAND AND WALES: VISION AND VALUES

Mike Longfield

Introduction

This paper sets out the professional codes of conduct within which prison doctors and prison nurses are expected to work, together with the statutory frameworks in which prisons must operate. The paper lists various ethical codes and statements which have been promulgated at various times. Most of these have relevance for all staff in contact with prisoners, but they have a particular relevance for the professional health care staff, who may be called to account by the relevant registration bodies, if it can be shown that they have failed to comply with the high standards required.

Key principles are outlined, which underpin the provision of prison health care in England and Wales, using various documents published by the Prison Service. These attempt to set out the values and goals of the Service and the minimum standards which must apply. In recent years strategic aims for the development of prison health care in England and Wales have been devised. These are discussed briefly, particularly in relation to the reorientation of the Service towards the promotion of health.

It is of course not sufficient to set out noble ideals. These must be translated into practice and the paper concludes with a description of the methods which are being adopted to achieve the vision. This clearly relates to the future organisation of prison health care, which is briefly described.

Professional codes of Conduct

All doctors working within the prison system must act in accordance with guidance issued by their registration authority, the General Medical Council (GMC). In October 1995 the GMC circulated guidance to all doctors[1], of which the following have

particular importance in the prison context, since they may have the potential to create ethical dilemmas for prison medical officers.

- *Good clinical care:* Make the care of your patient your first concern; maintain good standards of practice and care.

- *Keeping professional knowledge and skills up to date.*

- *Maintaining trust and confidentiality:* respect the dignity and privacy of the patient; respect the patient's views and the rights of patients for a second opinion; do not allow your views about a patient's lifestyle, culture, beliefs, race, colour, sex, sexuality, age, social status, or perceived economic worth, to prejudice the treatment you give or arrange; respect and protect confidential information - do not pass on any personal information which you learn in the course of your professional duties, without the patient's agreement, subject to exceptional circumstances. (This element of the guidance has particular relevance to infection with the human immuno-deficiency virus (HIV) and to patients suffering from AIDS.)

- *Research:* If you are taking part in research involving patients, you must ensure that the research is not contrary to the patient's interests and that it has been approved by a properly constituted research ethics committee.

Professional conduct for nursing, midwifery and health visiting is determined by the United Kingdom Central Council (UKCC)[2]. Unlike doctors, nurses can be punished by their registration authority, simply for breaching the code. Among other things, it requires practitioners to:-

- Safeguard and promote the interests of individual patients and clients.

- Serve the interests of society.

- Report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice; or any circumstances in which safe and appropriate care for patients and clients cannot be provided.

One can immediately see how particularly pertinent these professional codes are likely to be in the custodial context.

Statutory Frameworks for Operating Prisons

In 1987 in Strasbourg, the Council of Europe issued a revised European version of the standard minimum rules for the treatment of prisoners. Rules 26 to 32 of these **European prison rules** concern medical services. These state:-

- At every institution there shall be the services of at least one qualified general medical practitioner and a qualified dental officer.

- The medical services should be organised in close relation with the general health administration of the community or nation; and shall include a psychiatric service for the diagnosis and treatment of mental abnormality.

Certain principles are immutable and should be regarded as paramount.

- Medical officers and their staff have a primary responsibility for the medical care of the prisoners in their charge.

- Medical treatment and decisions should be made on professional advice and solely in the interests of the health and well-being of the patients.

- Any prison management or administrative decision that overrides or conflicts with a medical view should be reported to a higher authority and be susceptible to review.

- Prisoners may not be subjected to any experiments which may result in physical or moral injury.

This last requirement is also underpinned by the provisions of the European Convention on Human Rights and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

In British prisons the **Prison Act 1952** requires the appointment of a medical officer for each prison. The **Prison Rules** and **Young Offender Institution Rules** set out a range of specific duties, for which the medical officer is responsible. These include:-

- Overall responsibility for the care of the physical and mental health of the prisoners in that prison, whilst having discretion to call another medical practitioner into consultation.
  (Note the importance of prison doctors being able to exercise this discretion to arrange a second opinion since, in the context of custodial care, prisoners have lost the right to choose their medical practitioner in the way that a member of the public can select or change their general practitioner.)

- Regularly inspect the food, both before and after it is cooked, and report any deficiency to the governor.

- Excuse a prisoner from work, or from physical education, on medical grounds.

- For prisoners removed by the governor from association with other prisoners, under Rule 43, whether for the maintenance of good order and discipline, or in the prisoner's own interests, the medical officer can require the governor to arrange for a prisoner to resume association.

- In relation to the use of restraints, medical officers must inform the governor whether they concur in any order for a prisoner to be put under restraint and, if not, to require the governor to act on any recommendation.

- Direct the restraint of a prisoner, when required on medical grounds.

- Certify that a prisoner is in a fit state of health to be punished by confinement to a cell.

Ethical Aspects of Prison Health Care

There have been a number of declarations concerning the treatment which may be accorded to prisoners during their confinement. In its Declaration of Tokyo in 1975, the World Medical Association said that 'The doctor shall not countenance, condone or participate in, the practice of torture, or other forms of cruel, inhuman or degrading procedures.'

This specifically covers the situation where a prisoner refuses nourishment, since the Declaration states that where prisoners are considered by a doctor to be capable of forming an unimpaired and rational judgement concerning the consequences of such voluntary refusals of nourishment, they shall not be fed artificially. Our own policy in prisons in England and Wales is entirely consistent with this, since we do not force-feed prisoners who are refusing food.

On 25th June 1984 the Home Office wrote to all medical officers working in prisons concerning the United Nations Declaration on the principles of medical ethics. In December 1982 the United Nations General Assembly adopted a set of 'principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other crimes, inhuman or degrading treatment or punishment'. The code set out six principles of medical ethics to protect prisoners and detainees against such actions and the circular letter from the then Director of Prison Medical Services (Dr John L Kilgour) was designed to implement the request by the United Nations that governments should give the resolution the widest possible distribution, in particular among medical and paramedical associations and institutions of detention and imprisonment.

Following the abuse of psychiatric treatment in the [former] Union of Socialist Soviet Republics, the World Psychiatric Association published in 1983 its **Declaration of Hawaii.** This provides guidelines to promote high ethical standards in psychiatry and to prevent the misuse of psychiatric concepts, knowledge and technology, particularly in secure accommodation and prisons. The Declaration includes specific guidance on the conditions of compulsory treatment for mental illness, on the preservation of

confidentiality, and the requirement for specific consent for teaching and research.

The British Medical Association has taken a particular interest in cruel and degrading practices since Amnesty International issued its 1984 report *Torture in the 80s*[3]. In 1986 the Association produced its first torture report[4] and in 1992 a far more comprehensive work, entitled *Medicine Betrayed*[5] The report concluded that prison doctors have a particular duty to be vigilant, given the potential for abuse which can occur in prisons. It concluded that the contractual terms of prison doctors should acknowledge their professional independence to make clinical judgements and recommendations for treatment. Doctors working in prisons should be in a position to provide the same standards of medical care as is available to the general population. In particular they must be able to keep independent, confidential records. The report stressed the importance of doctors working in the Prison Service being able to appeal to an independent authority in the case of potential breaches of medical ethics. Incoming doctors should receive guidance on medical ethics and doctors working in prisons should have the opportunity to rotate jobs, so as to widen their perspective. The report provided specific guidance on doctors' involvement with a variety of tasks which are likely to be in conflict with normal medical practice. These include the care of patients on hunger strike; the forcible administration of medication for non-medical reasons; withholding of medical care; the forcible examination of prisoners, including intimate body searches; the forcible taking of blood or tissue samples; the assessment and treatment of asylum seekers; and experimentation on prisoners.

Katarina Tomasevski[6] reviewed international standards of prison health and national practices in Europe. She highlighted the

quintessential dilemma faced by prison doctors - their involvement in the medical screening of prisoners facing, or undergoing, punishment or physical restraint. Tomasevski acknowledges the difficult task of prison doctors in balancing the need to select out some prisoners for whom the punishment or restraint is likely to inflict serious physical or mental harm, against being seen to be a passive participant in the infliction of punitive procedures that have the potential to cause harm.

Key Principles Underpinning Prison Health Care in England and Wales

The principles adopted for the provision of health care in prisons are summarised by the following four documents:-

• HM Prison Service corporate plan.

This includes a statement of the values which are considered important for running prisons. They include:- integrity; commitment by our staff and to our staff; **care for prisoners** - treating them with fairness, justice and respect as individuals; **equality of opportunity** and the **elimination of discrimination;** innovation and improvement, including the delivery of continuous improvements in quality and efficiency.

The principal prison service goals include:- providing decent conditions for prisoners and meeting their needs, including the need for health care.

• Prison Service Review

In October 1996 this Review proposed some revision of the Prison Service's statement of values, but the new values will continue to place great importance on respect for prisoners as individuals. The Review considered that values go to the heart of organisational

culture and it set the seal on the kind of service the Prison Service wishes to be. The current statement of values is seen as no longer entirely relevant, being too elaborate to have an effect on behaviour and performance and not well reflected in everyday behaviour and style. The suggested new set of values includes upholding the law; **respect for the individual;** belief in the capacity for change; **trust** and teamwork. It should also be noted that the Prison Service Review makes important recommendations on ministerial responsibility for the Prison Service; **focus on regimes;** and improving managerial effectiveness.

• Custody, Care and Justice

In 1991 the Home Office issued a Government White Paper *Custody Care and Justice,* which set the way ahead for the Prison Service in England and Wales. In regard to prison health care, the White Paper set the aim of achieving equivalence with the National Health Service.

• Health Care Standards for Prisons in England and Wales

These standards also set out the aim of equivalence. They require a standard of care for prisoners that is comparable to that which they would receive in the community outside prison and they endorse the need for health practitioners to maintain the highest professional and ethical standards.

Strategic Aims for the Development of Prison Health Care in England and Wales

Clearly much remains to be done to bring prison health care up to a common standard across all establishments. As the recent paper by Reed and Lyne[7] points out, there continues to be considerable variation in the quality of prison health care. My analysis of the priority issues requiring focused attention in developing

prison health care suggests the following four main strategic priorities:

- Promotion of health.
- Provision of effective health services.
- Continuing professional development of prison health care practitioners.
- Research and development in relation to health in prisons.

Achieving the Vision

The identification of a vision is helpful, but will achieve nothing unless steps are taken to implement it. What is therefore being done, or planned to do, in order to achieve the vision in relation to the following four important areas?

Supporting health in prisons through the national health strategy

The background to developing a health promotion philosophy and practice in prisons in England and Wales can be traced through the following successive developments.

The 1992 Government document The Health of the Nation[8] for the first time set out a health strategy for England. Prisons were included in a list of settings in which progress could and should be made in health promotion. In the same year - a key year for us - the Prison Medical Service was relaunched as the Health Care Service for Prisoners. The change of name symbolises a new, more comprehensive view of health, which included the prevention of ill health, as well as the treatment of disease. Both developments were manifestations of a change in philosophy which had its

origins in the World Health Organization *Health for All by the Year 2000* strategy and the Ottawa *Charter for Health Promotion*[9].

One more important development for the Prison Service took place in England and Wales in 1992. An independent Health Advisory Committee for the Prison Service was established, under the chairmanship of Sir Donald Acheson, a former Chief Medical Officer to the Government and himself a very eminent and influential public health doctor. Under his chairmanship the Committee took a keen interest in health promotion in prisons. It sought to build on the foundations laid in *Health of the Nation.* With the enthusiastic support of the Health Advisory Committee, the Directorate of Health Care, under its then Director, Dr Rosemary Wool, entered into a dialogue with the World Health Organization (WHO) to see if this 'settings approach', which had brought such benefits to other areas, such as cities, schools, hospitals and workplaces, could usefully be adapted to prisons. The World Health Organization was receptive to the idea and a meeting of interested countries with WHO was held in London in October 1995. The meeting concluded that health not only could be, but in all our interests should be, promoted in prisons. The Prison Service Directorate of Health Care was designated as a Collaborating Centre in May 1996. The aims of the WHO *Health in Prisons Project* are 'to promote health in its broadest sense within the prison community. . . . . [to use] time in custody positively for the prevention of disease and the promotion of health, and [to reduce] negative effects of custody on health to a minimum'.

At a more domestic level and in order to acknowledge and promulgate the many examples of good practice on health promotion in our prisons, we launched in 1996, for the first time, our *Health Promoting Prison Awards Scheme.* The scheme was

devised and overseen by a Joint Committee, whose membership included representatives from the Directorate of Health Care, the Health Advisory Committee, Her Majesty's Chief Inspector of Prisons, the Department of Health and the Health Education Authority.

The scheme is an opportunity for prisons to gain credit for being able to demonstrate an overall strategic and multidisciplinary approach to promoting health in prison and achieving good practice across a range of health promotion initiatives. There were four Gold Award winners for the 1996/97 scheme and a total of 22 prisons gained awards or certificates of commendation. The ideas and initiatives by the award winning prisons were promulgated in a *Good Practice Guide,* which was issued in March 1998[10].

Effective commissioning of health care services

The Health Care Service for Prisoners intends to move towards a model of **commissioned** health services for all prisoners:

- On the basis of prioritised health needs.
- Utilising evidence-based health care interventions whenever possible.
- Setting standards and levels of health care provision.
- Monitoring and auditing health care provision to ensure continuous improvement in the quality of patient care to match that in the community.

- Building health alliances with statutory, voluntary and private sector agencies in the community.

- Based on a rational model of resource allocation.

Linkages with professional Royal Colleges and academic institutions

In order to reduce the risks of professional isolation, the Service is supporting the recruitment and continuing professional development of prison health care staff to:

- Provide a clinical competence framework for clinical staff working in prisons for use in recruitment, performance appraisal and the identification of training needs.

- Develop policies and practices which reduce the isolation of prison health care practitioners and encourage the interchange of ideas and experience with the National Health Service and other health service providers.

- Take the learning points from clinical complaints and identify the remedial action required.

Health research strategy and ethics committees

There remains a need for research to be undertaken within prisons and the knowledge obtained from so called 'evidence-based medicine' should be applied within the prison setting. In order to support the research and development role in relation to health in prisons, it is intended to:

- Establish a 'Cochrane-type' database of effective prison health interventions.

- Provide a strategic framework for health related research.

- Ensure independent research ethics committee approval for all health research in prisons.

- Benchmark and disseminate good practice.

Future Organisation of Prison Health Care

Driven by a consideration of the discussion paper produced by Her Majesty's Chief Inspector of Prisons, *Patient or Prisoner*[11] and by the need to take forward the many important recommendations by the Prison Service Health Advisory Committee in its recently published Mental Health Report[12], ministers from the Home Office and the Department of Health recently authorised the setting up of a Joint Working Group. This Group between the Department of Health and the Prison Service was established on a continuing basis in November 1997, to explore the options for the future organisation of prison health care. It is an important opportunity to redefine the relationship between the National Health Service and the Prison Service and perhaps to reset the boundary of the interface between the two services. Whatever the precise form of outcome, it is likely to promote greater collaboration between the two departments and the introduction of a closer partnership to finding solutions for quality prison health care. It is likely that the outcome of this work will need underpinning by legislative changes which, in turn, will provide the opportunity to revisit the present requirements in the prison rules on doctors working in prisons.

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6. GENERAL DISCUSSION

Stuart Horner and Meg Stacey

The wide range of people who attended the conference included doctors (one a senior prison medical officer, others with experience in prisons), nurses, prison officers voluntary workers, as well as academics and other interested persons. After hearing the speakers, the conference divided up into three working groups addressing respectively

- whether prisoners are less eligible for medical care than those outside;
- whether doctors experience a conflict between being a provider of health care and a part of a custodial organisation;
- the statutory responsibilities of health care professionals under prison rules.

Each group later reported to a plenary session at which all the opening speakers were present; general discussion followed the reports. This chapter addresses the main themes which emerged.

- A lack of clarity in practice about what and who prisons are for.
- The role of health care professionals in prisons.
- How to balance the demands of security and those of providing health care.
- The use of resources
- The gap between vision and actuality and the changes afoot.

What and who are prisons for?

Apparently the Victorians were clear what they were about: those sentenced were deserving of incarceration and were locked up because they were too dangerous, either morally or physically or both, to be at liberty. Not only so. They were also 'less eligible' than other members of society to receive care. Today there is less clarity, but elements of 'less eligibility' remain. A medical officer can, for example, authorise the provision of less food to a prisoner than that ordinarily provided. Is such action intended to treat the prisoner, for obesity for example, or to inflict punishment under the 'less eligibility' criteria? Prison diets are in any case sparse. Anxiety was expressed that private prisons operating for profit might increase the confusion.

A fundamental point on the purpose of prisons was raised by Joe Sim in discussion - the belief, apparently held in the UK and the US, that the more prisoners the less crime, whereas there was no evidence in either country of such a correlation. There will be 140 or 150 prisons by the century end, 130,000 to 140,000 police officers and a major security industry. All this appears to be having little effect on the crime rate.

Participants suggested, furthermore, that there is lack of clarity about when prison as a punishment is necessary and when non-custodial alternatives might be more appropriate. Why was the number of women prisoners rising? The incarceration of women for the non-payment of fines or TV licences were cited as stark examples, especially as incarceration removes from women any chance of working to find the necessary money to rehabilitate herself.

The conference accepted that some people had to be removed from society, but it was hard to see the logic behind the wide

variety of offences for which imprisonment was seen as appropriate. If the starting point was that prisons exist to remove from the community those who behave seriously badly and to retrain them, maybe not so many people would be imprisoned and other arenas found for the training process. However, difficulties emerge. Given the concept that prisons are as punishment, not **for** punishment, 'humane containment' is proposed, that is attempts are made to minimise the damage prisons can do and to try to ensure that prisoners have, as far as possible, the same lives they live outside. But it seems difficult to build an ethos around this approach and historically the pendulum has swung back to punishment and deterrents. Or, if the ethos is accepted and retraining attempts are successful, it is only with selected groups, leaving a residuum for whom there seems nothing to be done.

Evidence here came from Joe Sim's research in the 1960s in Barlinnie where equality of practice was established in the Remedial Unit for some of Scotland's most dangerous and problematic prisoners. Here officers and prisoners were on a par in so far as each week all had to sit and account for themselves if they had broken rules or codes. Some prisoners could not do it and asked to be transferred back to traditional harsher regimes. Yet many changed. The philosophy and the staff were 'brilliant', although the Unit did have conflicts and problems[1]. The previous Conservative government closed the Unit.

A participant echoed the vision behind Barlinnie speaking of the need to engage with prisoners as persons; a prison officer, a doctor, a nurse, or any other worker should see prisoners as individuals thus avoiding dehumanisation. This was the way forward.

The role of health care professionals

Medical staffing arrangements were reported as follows. Local prisons which serve specific catchment areas and hold a high proportion of remand prisoners are staffed by a full-time medical officer (MO) or a senior medical officer (SMO) with other MOs under her/him. Smaller local prisons for sentenced prisoners tend to be staffed by part-time officers who may be general practitioners from local practices. While it was claimed that MOs or SMOs are accountable to the governor who signs his/her annual appraisal, another view was that medical staff reported to the governor but were accountable to the area health care advisor who is also their supporter. The governor is a civil servant, ordinarily without medical background, and has major concerns with security. Both governor and MO are civil servants, but although medical salary grades in prison tend to be lower than those outside, an SMO's salary may be higher than that of the governor. Salary grades are in general lower than those outside, although this is beginning to change. Part-time medical officers, for example GPs in the NHS, contract services on a sessional basis and perhaps have more independence. Accountability for both full-time and part-time medical officers seemed to contain ambiguities.

An MO's professional ethics stress confidentiality but in prison s/he may experience requests to disclose confidential information; the treatment of patients with HIV and of drug users may be constrained by prison rules which prevent the use of the doctor's treatment of choice. Condoms are not permitted nor is a needle exchange system. Prison doctors may suffer from professional isolation; they are not yet represented by the British Medical Association, few are members.

Medical officers have a legal obligation to obey prison rules and are required to sign the Official Secrets Act. The rules lay certain responsibilities upon medical officers such as for excusing a person from shaving or insisting upon shaving. Medical officers are involved with issues of restraint, removal from association with other prisoners (i.e. being put in solitary confinement), alcohol, tobacco and food.

The demands of discipline and security versus the demands of health care

While at least one senior medical officer was clear that for health professionals the needs of health care must take priority over security issues, the latter being the governor's responsibility, participants reported problems in practice where the boundary between health care duties and security duties seemed shady. The medical officer's power to certify people as fit for confinement in their cells and for medical restraint can lead to conflict. These powers exist ostensibly to protect the prisoner. However, many prison nurses and some doctors carry cell keys and sometimes let inmates in and out of their cells; an incident was reported in which having received verbal abuse from an inmate, an MO immediately put the offender in confinement. One particularly acute example facing MOs was the use of strip cells and of the one-piece suit - here a clash between prison values and professional values was apparent. Variation between prisons was widely reported. In some a good relationship between an enlightened governor and health care staff helped health care programmes move forward.

In the past most nursing care was provided in a punitive culture by personnel with a prison officer background and scant retraining. The appointment to prisons of more nurses from the NHS may help to change attitudes as time goes by. Whether contracting

health care out to the NHS would resolve the problems did not become clear. A completely independent health care service would never be possible because an interface would always exist between health care services and the prison administration and management. At the opposite pole from the punitive ethos was the view that health care staff's task is not only to look after the patients' heath but act as advocates on behalf of prisoners seeking to convince custodial officers, governors and kitchen staff to plan for better health for prisoners - a move to 'healthy prisons' in effect.

In contrast to this vision, reports of past and continuing brutality by prison officers towards prisoners were voiced, suggesting a punishment orientated 'less eligibility' attitude may still prevail in some prisons. Mike Longfield reminded the conference that the prison officer's role has been redefined to include elements of caring and welfare and that, as with nurses mentioned earlier, the appointment of new officers trained in interpersonal skills to work with prisoners hopefully should gradually change the situation, although it would be neither easy nor quick.

The use of resources

Throughout the discussion questions arose about the resources allocated to law and order and specifically to the prison service and how they were divided up. Those trying to humanise prison health care and to take both a more humane and a more preventative and health promotive approach reported coming up against resource problems. Thus one senior prison officer was of the view that relations with the governor were less the problem than resource constraints trying to improve health levels. Joe Sim insisted, however, that £7bn spent on law and order services was a lot of money and that the problem lay in its allocation: security and

control took precedence leaving resources short for other activities. Mike Longfield indicated that much is being done to raise the management competencies at all levels but particularly at middle management and governor level. However, he also said the health budget is not ring fenced. Health needs assessment, he agreed, was not a developed art in prisons but is just being developed in conjunction with public health departments. He anticipated these assessments would identify a need to revise the budget and move existing money around the system.

Conclusion: the gap between vision and actuality and the changes afoot.

Overall three points emerged. One is the great variability in the standard and practice of health care in prisons, of relations between governors and health care staff, between prison officers and health care staff; variability, too, in the extent and harshness of the punitive culture. Second, that much work was needed to raise the overall standard to that of the best and to move towards the best possible. Third, fundamental reorientation was needed but the conference recognized that government was attempting by new policies and procedures to move in that direction.

In answer to a question as to how one could move out of the spiral of budget cuts in favour of greater security towards meeting articulated health needs, for example for decent food, provision of mental stimulation or physical recreation, Mike Longfield said there were encouraging signals. Ministers had agreed that the prison financial audit and the prison service review should be published, so the extent of under-resourcing would be revealed and an understanding reached as to whether resources needed to be spent on developing the regime at the expense of security and control technology. He recognised that there was a point in

security and control when the law of diminishing returns began to apply. After efficiency savings had been made ministers would have to grapple with any need for additional resources - a difficult but necessary political task.

Throughout the discussion the isolation of health care professionals was mentioned, suggesting that this made it hard for them to maintain their professionals standards. The conference had not been able to resolve the question of whether having the NHS run the prison health care system would necessarily help. Nor was the issue of protection for whistle blowers resolved. It was, however, urged that audit of prison health care should be independent and not undertaken by the prison service. Hitherto the prison ombudsman's remit had not extended to clinical complaints but there was hope that a revised complaints system would include them.

Overall it could be said that participants felt there was a long way to go before the practices of all prisons met those of the best, when a situation might be reached where humanity in health care prevailed and a move nearer to what some saw as the huge potentials available for improving prisoners' health care and health during incarceration and avoiding ill health and recidivism could be made. Tension among goals and dilemmas requiring resolution would however be everpresent.

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1. See Boyle J. (1977) *Sense of Freedom.* Edinburgh, Canongage and Boyle J. (1984) *Pain and Confinement.* Edinburgh: Canongage.

7. CONCLUSIONS

Meg Stacey

In calling a conference on human values, health care and British prisons, the Forum was pursuing its intention to examine circumstances where doctors and other health care workers might be at risk of jeopardising their avowed 'healing mission' - to use Robert Lifton's phrase[1]. The Forum recognises that, in the absence of attention and resolve, anywhere, at any time (including here and now) the healing mission could be compromised. So the emphasis on British prisons was less ethnocentrism than a recognition that it is not only others who make mistakes and commit errors, intentional or unintentional. Prisons, by their very nature, are precisely places where the healing mission can be put at risk. The tensions between punishment and health care, between security and health care, provide circumstances where in practice clear heads and strong resolve may be needed to maintain crucial human values. Cultural, structural and moral phenomena are all involved in these conundra.

The evidence which we heard during this day conference was upsetting, enlightening, optimistic and worrying all at once. Upsetting, because of the continuing problems revealed, not only by the speakers but by participants who worked in a variety of ways in British prisons. Enlightening for those of us with little knowledge of the present-day British prison scene; enlightening also because speakers and participants helped us to understand something of the nature of the dilemmas faced by those who work in prisons. Optimistic because we heard of the new government-backed plans for reform of the Prisons Health Service. Worrying because of the major gap between that vision and what we heard of the reality in some prisons and of the spiritual neglect of ethnic minority prisoners which emerged. Questions left to haunt us were 'Are we now able to learn the lessons of history?', 'Are prisons and health compatible or is a healthy prison a contradiction in terms?', 'What are prisons for anyway?'

As Joe Sim reminded us, there have in the past been outstanding doctors who resisted harsh (and unhealthy) prison regimes. Others put the full weight of their authority behind whatever discipline the governor required, caring, as he put it, for the order of the prison rather than ordering the care of the prisoners. Not only in Joe Sim's historical account, but in contemporary evidence offered, it is clear that in Britain we have not thought it sufficient that persons convicted of offending against the law should be deprived of their liberty - no going home after work, no popping out to the shops, no partner, family or friends nearby.

Prisoners have readily been assumed to be malingering or 'shamming'. Doctors have at various times sanctioned the dubiously appropriate use of treatments such as cold water, strait jackets, electric shocks, psychotropic drugs and strip cells - those cells which are stripped of every mortal thing, as is the prisoner. These last being used for out-of-control prisoners who, perhaps, had greater need of careful psychiatric care.

In these and other ways prisoners have historically been considered less eligible for decent treatment than those outside and this has included health care. Not only so, prisoners experience a less than healthy environment and are more sick than the population at large. While prisons today vary, prison austerity still prevails, as the 1997 data from the National Audit Office about the very low budget spent on food shows (see p.31).

The punitive, disciplinary and often violent culture described by conference participants still prevails in many prisons (see pp.84-85) and, one must add, is echoed by the public and the media outside. This care-less ethos plays its part in the deaths which occur in detention, whether in prison or police station, as the evidence of

Ward and Coles showed. The death of Kenneth Severin, a mentally-disturbed African Caribbean man arrested for attempted burglary, was due to positional asphyxia (caused by the manacled position in which prison officers left him in the strip cell). (See pp.38-42). He was the victim, it would seem, of the culture which blames the victim and turns to violent solutions, but the victim also of structural fractures between the nursing and medical services and the prison officers, compounded by a lack of proper education and training of the latter and of the nursing staff. The upshot was that no one knew Severin as a whole person and no one, apparently, was responsible for his death. A victim, Ward and Coles suggest., of that 'terrifying contraption'[2], the bureaucratic apparatus of the modern state, which tends to produce a moral vacuum where human lives are involved. In the case of Kenneth Severin the prison officers said (inaccurately) they were following prison rules. Rather, they seemed to have been following (unacceptable) custom and practice.

There is no doubt that the plans for prison health reform which Mike Longfield presented recognise and seek to overcome many of the health problems which exist in prisons. Less eligibility is to be left behind, the aim of equivalence is explicitly stated. In support of this health care, staff are now told to follow professional standards; this should strengthen them when nursing or medical needs come into conflict with punitive, disciplinary or security requirements.

The October 1996 Prison Service Review recognised that the current statement of values was not well reflected in everyday behaviour and style. Among the new set of values offered, Mike Longfield emphasised respect for the individual and trust (see p.72). The 1992 *Health of the* Nation[3] included prisons for the first time and the Prison Medical Service became the Health Care

Service for Prisoners. Driven by the initiatives from World Health Organisation, stress is being placed on health promotion, and a Health Promoting Prisons Award Scheme has been instituted with the aim of encouraging 'healthy' prisons. This is perhaps the nearest that the plans Mike Longfield described came to practice in the prisons, the prison cells and the prisoners. These proposals offered hope for a break with the past. At least the words that guide the service break the mould. Will the punitive culture change to match? Newly recruited prison officers trained to recognise the value of the individual, closer connection with the NHS, should all help. Doubts remain.

In a context where the number of people being sent to prison is still increasing, when new prisons are being built, when the strong emphasis is on law and order, one wonders. A continuing climate of fear of offenders still seems to prevail, along with the stress on prison security it evokes. Will the necessary transfer of resources within the prison service to health and welfare really come about in this climate?

Nothing in Mike Longfield's talk addressed the serious issues of the spiritual health of prisoners, its connection with physical health and illness and perhaps, particularly, with mental health. Nor did a viable number of conference members sign up for a workshop around this topic. Both these omissions are indications of how little had been known or thought about it, until Beckford and Gilliat presented their research.

Their data showed a decline in the numbers registering as belonging to a Christian denomination, an increase in those declaring they have no religion, but a clear increase in the numbers of prisoners of 'other faiths' (i.e. believers who are not Christians).

(See Table 2, p.54). The last increase reflects the multi-ethnic and multi-faith reality of modern Britain. Beckford and Gilliat's findings revealed serious deficiencies in the service available: first, in the small amount of connection between chaplains in general and the health service; second, in the uneven availability of chaplaincy services over the spread of faiths.

The origins, for persons of all faiths, of the weak connection in the majority of prisons between chaplains and health carers did not become clear. However, the second deficiency seemed to have a structural origin. The Anglican church has the statutory responsibility for the provision of the chaplaincy services. The access and funding of other denominations and other faiths, are dependent on the goodwill of the Anglican chaplain, which varies from prison to prison. The prison service chaplaincy, the senior members of which are Christians, receives public funding. While arrangements with various Christian denominations have developed and improved over time, this has not yet happened with other faiths, for some of whom connections between medical and spiritual health may have a special meaning and particularly perhaps in the diagnosis and treatment of mental illness. This *de facto* discrimination against ethnic minorities and other faiths remains a worry. A ray of hope is that the research was instigated by the Archbishop of Canterbury. May he not allow it to gather dust!

These gaps in the service to prisoners we may deplore; but there was another gap. No contribution was invited from a serving prisoner (which might have presented difficulties), or an ex-prisoner (which should have been possible and instructive). That was clearly a serious omission and we all missed out on what we might have learned and understood better. We had to rely on interpreters and students of prisoners' problems and points of view.

In that omission, writing as a prime organiser, this author has to confess that she herself fell into the ancient 'less eligibility' trap, seeing prisoners and ex-prisoners as 'the other', not one of us, to join in our deliberations. As this publication was going to press we were fortunate to discover a document written by two prisoners from within the prison system. It does not seek to sentimentalise prisoners - one freely admits that he deserves to be imprisoned. It is, however, a heartfelt protest against the inhumane conditions in today's prisons which had surfaced from time to time during the conference. We have included some extracts from this extraordinary document, which has not yet been formally published, as Appendix 1.

Yes, how far we as a country have to go before we can be sure that the health of prisoners is cared for in the full understanding that, as human beings, prisoners are as much to be valued as any of us on the outside. The state has taken their liberty, to take more of their humanity is unacceptable. Prisons and health may be a contradiction in terms; maybe they can never go together. Prisons could however undoubtedly be healthier and human values better preserved. The examples of good practice demonstrate this.

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APPENDIX 1 ***THE PRISONER'S TALE***
Prepared by Stuart Horner

We have been greatly exercised by the fact that the conference contained no input from a former prisoner. There were some hints during the day from those with experience inside prisons, that inhumane practices continue. During the discussion Dr Macara (now Sir Alexander Macara) had referred to some work carried out in the 1960s into the brutalising effect of prisons, not only on prisoners, but on their custodians. We attempted unsuccessfully to trace written references to this work, but in the course of these investigations we were given a copy of an extraordinary manuscript completed by two prisoners, Andrzy Jakubczyk and Paul D Ross. They had completed two editions of a document ***One Off*** *whilst in the educational unit at Hull Prison. The document which was written six or seven years ago, but after the Woolf Inquiry, gives a harrowing account of the way potentially suicidal patients are treated in prisons. During 1987 and 1988, 159 people died in English and Welsh prisons, of whom 67 committed suicide*[1]*. This appendix briefly summarises the* ***One Off*** *document and then gives a detailed statement from each prisoner of his personal experiences, whilst attempting to compile a third copy of the report. It should be emphasised that neither prisoner is contesting the decision that he should be punished by a term of imprisonment.*

Both, however, fiercely object to the treatment that they and other prisoners have received which, they believe, contravenes the United Nations Declaration of Human Rights and the European Convention on Human Rights. Both were then studying (under enormous difficulties) for degrees at the Open University. Their document is extremely well referenced both to prison procedures and to articles and papers in the general literature, which tend to corroborate the statements that they have made. Although a large number of copies of the manuscript have been circulated, some of

which are deposited in various university libraries, it has not yet been formally published. It is hoped that this account will provide a wider knowledge of its contents and assist the dissemination process. For the convenience of the reader editorial text is shown in italic type whilst the original authors words are shown in normal type.

One Off by **Andrzy Jakubczyk and Paul D. Ross**

The subject of prison suicide is an emotive issue. It is one which most people would prefer to put to the back of their minds and forget. It is an issue however that has always been a tragic facet and it should rightly be afforded greater attention and resources if we are to begin to understand it and its impact upon and implications for society as a whole. Ideally this will lead to its ultimate eradication. Most of those entering prison will leave at some future date (if ever), far worse than when they entered, as a consequence of the experience. This document is an attempt to reveal the nature of that experience covering virtually every aspect of prison life. It draws on a comprehensive range of criminological data and other professional research studies. It also draws upon the personal experiences of a number of inmates. Although this review provides a very critical view of the penal system generally, it is not intended to detract from the fact that there is a positive side to the system and that there are people within it who have a genuine commitment towards the reform process.

Many of those entering prisons have psychological problems, with the majority of them drawn from the ranks of the socially disadvantaged, the poor, less educated, unemployed, and ethnic groups. For these, imprisonment imposes additional difficulties that interact with pre-existing problems. Another vulnerable group are 'substance abusers', for whom the sudden transition from

community to prison creates psychological problems and who do not have access to the substances used to cope with the everyday stresses of life within the community. The group most vulnerable to environmental stress are the mentally disordered (who form a significant proportion of the suicide statistics). They lack the ability to develop adequate coping strategies. These problems are exacerbated by the total lack of outside support, of the sort which is central to maintaining any semblance of psychological stability. Consequently this leaves them feeling totally abandoned and vulnerable. ...

From the moment of reception into prison the person's identify is systematically stripped away. He is subjected to a formalised ritual of degradation and humiliation. His clothing is removed and taken away: it is replaced with the standard issue 'uniform'. If he is lucky the uniform will fit. He is allocated a prison number. That experience is a very subjective one. The effect of this on mentally ill and young offenders, particularly first time offenders, is in itself a traumatic experience. This is followed by confinement in a 12' X 8[1] concrete box with two, in some instances three, total strangers, under conditions which provide not even a minimum of privacy to perform basic natural functions. They are then exposed to a regime that is psychologically bleak and austere and which imposes maximum constraints on social interaction. Most prisoners manage to adopt the necessary coping strategies to come to terms with this 'depersonalisation process'. There is little alternative. They either accept it or reject it. In most cases acceptance is the initial step in a series of interactions designed to survive the experience. Most prisoners unquestioningly accept institutional intimidation as the norm. A visible minority however are unable to do so and this rejection manifests itself in various ways. For this minority life in prison becomes an endless circle of confrontation.

As a consequence, the resulting resentment, hostility and rebellion then brings into play the 'labelling process', which affects every aspect of the prisoner's life - categorisation; wing location; job allocation; etc. At one extreme end of the scale are those who reject outright the depersonalisation process and are labelled 'subversive'. At the other are those who are unable to come to terms with the demands of the environment and their situation and who perceive suicide as the only solution. Between are those who accept their situation and adapt to the environment purely as a means of hastening their release or parole prospects, or indeed merely enhancing their lot.

It has been estimated that there is one suicide or self-mutilation every day of the year in British prisons. One prisoner thought to be at risk of suicide described his experience.

> ... I was placed in a strip cell after receiving a life sentence for a crime I did not commit. A prison officer told the prison doctor that I looked very depressed …. I was immediately put into a strip cell, **in the hope that I would cheer up!** During the three days I had to endure in this cell I was denied access to the prison governor, my family, my solicitor ... my clothes were taken and I had only one blanket ... I had to sleep on the floor because there was no bed. Eventually I returned to the prison wing, even more bitter, angry and depressed than I had been three days earlier. A few months later the Appeal Court quashed my conviction and released me.

A former prison warder provides an even more graphic description.

> ... some inmates, more desperate, attempt suicide. This results in a fate worse than death if they fail. Most suicide attempts are nothing of the sort. The inmate, usually young and frightened, cuts his wrists or slashes his throat. More often than not the cuts are relatively minor; some rip right through veins and sever a main artery; the prisoner may bleed to death and be found as a corpse the next morning. The failures receive a more refined form of treatment. Standard practice for dealing with a failed suicide is to examine the prisoner for injuries and, if possible, treat them - stitch open wounds and dress [them]. The inmate is then moved to 'strip conditions' ... While ostensibly designed to protect the prisoner, it is used to deter him and others from such action. Strip conditions mean exactly that. ... Should an inmate in strip conditions decide to perform - scream, bang his head against walls, shout abuse - the likelihood is that drugs would be prescribed and forcibly administered. The prisoner then remains in the strip cell until he calms down, perhaps as long as a full week. My experience is that they are utterly changed when they leave the hospital after this treatment, which is more 'subtle' than The Block; but it offers the system an answer to non-conforming inmates.

The informal disciplinary process incorporates a diverse range of administrative procedures that may be implemented in conjunction with formal procedures ... or, they may be applied independent of formal processes, when formal procedures cannot be applied. Two examples of this are rule 43(b) and circular instruction 37/190. Rule 43(b) provides for prisoners to be

segregated indefinitely for reasons of 'good order and discipline'. It is one of the most frequently applied and abused provisions, resulting in prisoners being subject to long term social isolation, in some cases for years. Circular instructions are internal, unpublished management instructions, issued to penal establishments periodically by central office. Generally speaking they have no status in law. CI/37/90 is an administrative device that permits the transfer of prisoners deemed 'control problems' to local prison establishments, invariably into isolation conditions. The length of time varies between one to six months ... More often than not, prisoners subjected to this procedure are transferred under circumstances that flagrantly infringe fundamental rights, e.g. deprivation of personal property, ... disruption of visits and correspondence. So, although officially applied as an administrative procedure, it is experienced as a punitive measure and in most instances intended as such[2].

One disturbing practice is the use of prisoners by prison warders as a means of controlling the general prison population. The former prison warder described earlier made reference to this as follows: 'Staff usually have the ability to persuade the landing hard man to bend to their will. They point the finger, open the doors and, as if by magic, the recalcitrant inmate receives a going-over in the recess. No-one hears, of course.'

Rarely, if ever, is other than a cursory glance given to the world of segregation units and yet it is within this dark area of the criminal justice system that the more brutal aspects of the authoritarian structures are applied. Appropriately termed a 'prison within a prison', it is a physically and psychologically bleak world, of almost total social isolation, in which the prisoner quickly becomes acquainted with the full power of the state.

THE *PRISONER'S TALE*

The image of segregation units occupied primarily by individuals incapable of functioning on other than a confrontational basis who resort to violence on any or every pretext is a myth. Most of those undergoing protracted isolation are those who have come into conflict with the authorities .... A wrong word in a moment of frustration is sufficient to bring into operation the formal disciplinary process. From there, it can be and frequently is, a downward spiral in which the prisoner becomes trapped in a vicious circle of confrontation. In most instances conflict could be resolved without recourse to confrontation, or without undermining good order and discipline. More often than not, however, the authorities adopt a confrontational approach.

The purpose of isolation is to 'break down' the prisoner's self-perception and to restructure it by means of the formal and informal disciplinary process. In many cases however the process merely reinforces recalcitrant behaviour, or anti-authoritarian attitudes, which then justifies the use of protracted isolation. One of the inevitable consequences of long-term isolation is the undermining of the inmate's self-confidence and the erosion of social skills through disuse. Starved of all positive stimuli in a hostile environment, which appears specifically designed to frustrate basic psychological requirements, the prisoner becomes increasingly introverted and withdrawn. Interaction between the prisoner and the authorities is inevitably confrontational. As a consequence, the prisoner, understandably, comes to perceive himself in the role of victim.

Nigel Walker has pointed out that

> ... what prisons do expose their inmates to is the risk of assault by other inmates and to a lesser extent by prison

> officers ... imprisonment not only exposes prisoners to the influence of other prisoners, but also places them to some extent at the mercy of staff. The rules and standing orders which restrict or prohibit activities that would be unhindered outside, can be applied generously, or with bureaucratic strictness; they may even be applied vindictively ... unlawful or unnecessary exercise of authority by an officer is a disciplinary offence, which is spelt out as 'deliberately acting in a manner calculated to provoke a prisoner, or the use of unnecessary or undue force'. How often it occurs is hard to say: it is only exceptionally that it receives publicity, for example in the aftermath of the Hull riots ... occasionally an individual prisoner, whether through mishandling or because of his own aggressive personality, becomes more or less unmanageable; and it is these cases which give rise to proper concern.[3]

The document One Off also examines physical restraints, psychotropic drugs and special cells. The Prison Reform Trust[4] has claimed that the use of body restraints was 'concentrated in a small number of jails'. It named five prisons, i.e. Brixton, Feltham Young Offender Institution, Pentonville, Wormwood Scrubs and Full Sutton, as using body restraints more than the remaining 125 prisons put together.

The Trust describes one of the restraints as follows.

> The body belt is a legacy of the middle ages, still used in Britain's prisons today .... A body belt is not the [more] familiar straight jacket. It is a thick leather belt, approximately 4 inches wide, which is fastened round

> the prisoner's waist and which has handcuffs (iron for men, leather for women) attached to a ring on either side. The prisoner's feet may also be tethered with thick leather straps. According to prisoners with personal experience, when restrained in a body belt, a person's arms cannot be extended to their full length. The prisoner's body becomes hunched and cramp is likely to set in. Body belts are purchased by the Home Office in three sizes: a large and small size for men and a standard size for women. Prison rule 46 permits the use of restraints, where this is necessary, to prevent the prisoner injuring himself, or others, damaging property; creating a disturbance or for safe custody during removal; or on medical grounds by the direction of the medical officer. Under Home Office standing orders[5] any prisoner held in a mechanical restraint, or confined to a special cell, must be observed every fifteen minutes and visited by the governor and the medical officer twice every twenty four hours. Although it has never been tested in the courts, the body belt may well infringe that provision of the Bill of Rights 1689 [sic] which outlaws 'cruel and unusual punishments'.

[Despite strict guidelines for their use] ... prisoners held under restraint and/or in special accommodation invariably remain so for a minimum of twenty four hours. ... we know of no prison that complies with the provisions of the Standing Order, standard practice being for prison governors and doctors to see inmates only once during the course of their daily mandatory rounds.

The forcible administration of psychotropic drugs was an issue raised in the Woolf Inquiry, when it was revealed by a prison

doctor that psychotropic drugs were used as part of the informal disciplinary system. This kind of malpractice is not a recent phenomenon, but one that is a feature of a number of local establishments and, to a lesser degree, dispersal establishments. Again, as with mechanical restraints, authorisation for the administration of drugs is required from a doctor, but in many instances this is made retrospectively. It is of course difficult for allegations of forcible administration of psychotropic drugs to be substantiated. A prison warder, however, once stated in evidence: ' ... if the man refused the injection we would tell the M O [medical officer] and if he said we had to give it nonetheless, we would give it using minimum force ... '[6]. The overuse of psychotropic drugs for control purposes is still a continuing practice within the prison and the special hospital systems, particularly the latter. Of particular concern is the fact that this practice frequently involves the use of several different drugs, known as a 'cocktail'.

In July 1984 the Home Office recommended that there should be provision for alternative accommodation (special units) for the so-called hard core subversives to relieve the mainstream prison system of its more disruptive element. Selection and deselection would be centrally controlled by the special unit selection committee (SUSC), which convenes every six weeks and is supposed to be attended by representatives from each of the existing three units [Parkhurst, Lincoln (since closed), Hull and Woodhill].

The term 'special unit' is misleading and not to be confused with the more radical and forward looking regime of Scotland's Barlinnie Unit. The Hull Unit has been, and continues to be, incorrectly portrayed by both media and the prison department as a liberal environment where prisoners' 'every whim' is pandered to;

this is an untruth. ... [The unit] offers nothing that is unavailable elsewhere. Dubbed 'liberalism without reform' by resident prisoners, including those who have since relocated back into the mainstream prison system, the facilities are comparable to those within the dispersal system. The only unique feature distinguishing the unit from other prisons being the 'increased access' to facilities.

[By 1993, approximately four years after the unit became operational] almost incessant conflict and confrontation between warders and prisoners has been the norm. There has been a marked lack of consistency in the treatment of prisoners. Some prisoners have been given virtual immunity from disciplinary sanctions (up to a point) and others subjected to disciplinary sanctions for comparatively minor infringements.

Boards of Visitors have a threefold role - dealing with prisoners' complaints, observing and inspecting the prison conditions and a disciplinary role. Dubbed by prisoners as 'the rubber stamp brigade', they clearly have conflicting duties.

Rule 43(b) permits a governor to segregate a prisoner for any period not exceeding 28 days in the interests of 'good order and discipline'. After that period, a member of the board of visitors must endorse a decision to extend the segregation. That is the 'official' line. In practice, however, this rarely occurs. The decision to extend segregation indefinitely rests solely with the governor, or a subordinate governor grade, authorisation from the board of visitors being a formality usually 'rubber stamped' by phone, or made retrospectively if not immediately available. We have acquired evidence of this abuse of authority in which agreement to segregate a prisoner for a period of one and a half years was made

on the recommendation of a prison governor to the then director of regional office. This has been and continues to be a frequent practice and illustrates clearly the flagrant and contemptuous disregard with which prison staff regard formal regulations.

[A former member of the Board of Visitors resigned her position after approximately two years, out of an apparent sense of disillusionment. She summarised her views in an article for the Howard League for Penal Reform[7].]

> What became the final straw for me was the issue of suicide prevention methods. I cannot 'satisfy myself as to the treatment of prisoners' when they are held in strip conditions because they may be suicidal, when there are humane alternatives available. Due to whatever bizarre logic the Prison Department may invoke, resources will not be made available to care for and monitor suicidal prisoners on a twenty four hour basis, despite hollow policy statements to the contrary. Strip cells and virtual isolation for twenty four hours a day are the most barbaric conditions in which to keep anyone, let alone suicidal prisoners .... It remains to be seen whether Lord Justice Woolf's excellent report will be left to gather dust, just as has happened to previous reports, or whether any attempt will be made to implement the spirit of the document, let alone the proposals, not all of which have resource implications. ...

Andrzy Jakubczyk writes as follows

The ***One Off*** *was* an attempt to broaden people's awareness of the reality of imprisonment and we believe we partially achieved that

objective, but not without cost. ... The paper was not a pre-Woolf perspective, it provided a glimpse of a system that fundamentally remains unchanged, despite the Woolf Inquiry.

The eleven months preceding my deselection consisted of transfers from one segregation unit to another every twenty eight days[8]. Myself and my family repeatedly complained of this continuing isolation to the Home Office ... [the Prison Service responded] that I had been ' ... unable to settle at any establishment... ', this it was alleged had necessitated my inter-prison transfers. However, evidence has been acquired refuting this assertion and confirming that there had in fact been no intention to detain me at any establishment beyond a twenty eight day period ... in no way did I fulfil the criterion as a 'disruptive prisoner', having spent approximately two years at Hull Prison, during which period my conduct and that of my colleague Paul Ross was beyond reproach. The reality is that 'circuits' around segregation units remain a continuing practice ... the most obnoxious occurrence during the eleven months 'on circuit' were the constant attempts to ostracise me from other prisoners, by deliberate rumours being circulated by warders that I was a sex offender; [all my antecedents are for offences of dishonesty and prison protests]. Additionally, constant threats were made of transferring me to Liverpool or Wakefield prisons, two of the worst culprits for brutality in the United Kingdom.

In July 1993 I transferred to Wandsworth Prison, London, where I met my colleague Paul, who had been transferred there some two days previously. The encounter was short lived: Paul was transferred within forty-eight hours. His premature transfer from Wandsworth after only three days was unprecedented. Clearly the prison authorities did not want us together.

During the past year 'on circuit', numerous files of documentation disappeared from my property. In the main this consisted of legal correspondence, but also family letters and photographs accumulated over the previous eight years. There was constant interference with both incoming and outgoing correspondence. Additionally, as a consequence of these constant transfers, I was unable to continue my Open University course, on one occasion one hundred and thirty pounds worth of textbooks being lost by the authorities and never recovered.

Meanwhile, my colleague Paul was experiencing problems of his own. Transferred to Whitemoor Prison, his access to education was limited to formal education classes ... no third edition of ***One Off*** was possible. He was, however, able to make notes for inclusion in a forthcoming third edition, which he was later to pass on to me following our brief meeting at Wandsworth Prison in July 1993. Paul remained at Whitemoor Prison for six months. During this period he was allegedly 'destabilising the wing'; the reality was that he was encouraging other prisoners to utilise their academic abilities as a means of fighting for their rights. He was quietly and unobtrusively promoting the right of prisoner empowerment. Additionally his litigious reputation, which had resulted in many previous transfers, was perceived as a constant nuisance and threat by senior management. In summary, he was labelled a threat to 'good order and discipline' and perceived as a constant administrative headache.

Paul was subsequently reallocated to Long Lartin Prison, where he had transferred approximately two years previously. ... He remained at Long Lartin on this occasion for approximately two months, during which period he continued his civil litigation and involvement in prisoners' rights issues, with the inevitable

consequence that he once again became the target for hostility from prison warders. In September 1993 an incident occurred that was to once again ultimately result in his transfer. A 'psychologically vulnerable prisoner', who was experiencing difficulty in coming to terms with the manslaughter of his wife, requested segregation to have time alone. Following his voluntary segregation, a member of the senior management stated that the prisoner had requested segregation due to 'debts'. Paul and another prisoner reprimanded the governor concerned for his irresponsibility and demanded to see the prisoner to ensure his well-being. This altercation resulted in Paul and the other prisoner being transferred into local prison segregation conditions - in Paul's case Bristol Prison. In the meantime, the prisoner who had requested segregation was subsequently informed that he was responsible for the transfer of the two prisoners. This resulted in the prisoner seriously injuring himself and then attempting suicide. For this 'misconduct' the prisoner was transferred to the hospital at Winson Green Prison, where, far from being treated with humanity and understanding, he was located naked in a strip cell. It was known by the authorities at Long Lartin that Paul had exhibited an interest in this vulnerable prisoner and this was of particular relevance in view of our proposed further edition, at a time when criticism in relation to suicide and self injury was particularly rife. Paul's activities were both unwelcome and perceived as a potential threat.

Paul has been transferred between prisons on approximately twenty-four occasions during the course of his sentence. ... being a category A prisoner, he was never given any prior warning of pending transfers. This has invariably resulted in considerable personal property being lost between transfers. ... as a consequence of these transfers Paul's Open University studies have on

two occasions had to be postponed indefinitely, as a result of his Open University materials being left at other establishments, whilst other parts have gone missing, including his cassette and Open University tapes. In consequence he has missed a number of tutor-marked assignments. As if this were not enough, the governor of Winchester Prison refused him access to the educational department, with the consequence that he had no access to television, which forms a vital part of course programmes. He sat a pending examination within the prisoners' strip cell. All this will ultimately have detrimental effects on his examination results. ... Paul is currently subject to the outlawed 'circuit' of local prison segregation units[9], having been refused selection for a special unit by the Special Unit Selection Committee, on the grounds that ' ... he is not special unit material....'. The reality is that the Prison Department does not want the two of us together, given our previous 'misuse of the education facilities' in producing work critical of the prison system. Determined efforts have been made to preclude the possibility of a further production of ***One Off.***

By far the most disturbing aspect of the past year's events is the effect this has had on our families. We have had the support of family and friends; there are many prisoners currently subjected to the same practices which we have described who do not have access to such support.

Paul D Ross's account

For the most part, prisoners live under extremely oppressive conditions, month in, year out. They are permitted very little initiative, for there is no room for individuality. Initiative is frowned on; it attracts unwarranted and unwanted attention; it is therefore generally to be avoided. Most [prisoners] take what comes their way; they are conditioned into blind, implicit obedience, asking no

questions. In effect they become well-trained animals and thus any remaining sense of responsibility the prisoner may have had is gradually eroded to the point of extinction. There are, however, an increasing minority who speak out, some by means of direct physical expression, or by using the 'academic approach'. There is invariably a price for such activities. My colleague has described the events he experienced following the publication of *One Off.* I will now describe the circumstances surrounding the preparation of the second edition of *One Off.* The events detailed here are in no way unique and by comparison our experiences are insignificant compared to the subsequent treatment of prisoners involved in the April 1990 riots: one young protester hanged himself; one was transferred to Ashworth Special Hospital, following 'mental collapse'; many others continue to be subject to long term segregation. All this reinforces one plain fact: justice does indeed stop at the prison gate.

The preparation of ***One Off*** was a monumental task, given our situation. During the preparation of our paper, which could not be concealed, since we had to rely on the printing facilities of the education unit, there was a disturbing catalogue of events. We were very much aware of the resentment amongst warders, who viewed our work as a misuse of the education facilities. For the most part, we had no alternative but to tolerate this interference, being fully conversant with the workings of the informal disciplinary processes. Even a mere complaint could have escalated to a situation where transfer or deselection would have ensued and that appeared to have been the objective of management.

Prior to the circulation of our paper, we had invited comments from the Prison Service: we forwarded draft copies to various establishments, including the Prison Officers' Association,

explaining that we were researching the whole field of imprisonment. Not a single response was received. Telephone calls were made to ascertain receipt of the drafts, but the responses to these enquiries were, to say the least, hostile. (It should be noted however that our paper made reference to a number of official prison publications, official memoranda and an internal report by a senior psychologist, which was however extremely critical of 'staff practices'.) The response of management to our completed paper was hostile and we subsequently learned that a member of the Special Unit Selection Committee had suggested that the paper could be suppressed under prison standing order 5[10]. It is interesting to note that a copy of our paper was, however, requested by a private sector prison.

> ... prisoners considered for 'deselection' are, without exception, given some previous indication well in advance that a proposal for transfer is being considered. Prisoners are invariably given some choice in determining where they will be placed. It was 'suggested' I transfer to Whitemoor on a provisional basis, ostensibly for 'time out'. I declined the offer, but over the following days the Whitemoor transfer was repeatedly made. It was obvious that there would be no more papers and that the 'partnership' (as the warders referred to us) was to be severed at the first opportunity.

Clouds began to gather. My colleague and other prisoners stated that attempts to deselect me would result in their self deselection. A petition was also drawn up and signed by prisoners protesting at my proposed deselection. On 8th October 1992 my colleague was involved in an altercation with a fellow prisoner, who had been

relocated to the Hull Special Unit from Parkhurst Special Unit [this unit is specifically geared to the provision of treatment for those requiring psychiatric oversight]. I intervened in the altercation solely to prevent any escalation of violence. This incident however resulted in the opportunity management had apparently been waiting for. We were both removed from the prison under the circular instruction 37/90 provision, myself to Leeds Prison, my colleague to Liverpool Prison.

Because of the wide interest our paper had engendered, enquiries about our sudden departure had been anticipated. It was therefore necessary to provide some explanation. An article published in the national media implied that our transfers had been as a consequence of myself and my colleague 'fighting each other'. Andrzy Jakubczyk and myself returned to Hull Prison after the usual twenty eight day period. He was located to the segregation unit, pending the formal deselection process. I was relocated back to the unit. I was aware that my own deselection was now merely a question of time. I was transferred to Whitemoor Prison on 17th December 1993.

In addition to the considerable resentment surrounding the ***One Off,*** there was incessant suspicion in relation to the media focus our work had attracted. There is always a degree of paranoia on the part of the prison authorities where the media are concerned. The prospect of adverse publicity is viewed as a constant threat, particularly in the light of events over the past two years (1992/1993). Since the Woolf Inquiry this paranoia has, at many establishments, resulted in a proliferation of transfers and the use of 'circuits', transferring prisoners from one segregation unit to another. This practice was supposedly prohibited by the Government itself in its White Paper[11].

One significant event surrounding our deselection which provides a more accurate perspective, not only into the incident resulting in our transfers and subsequent deselection, but how our work was perceived by the authorities. It was a postcard sent to my colleague by a senior psychologist at Hull Prison which stated: ' ... my aim to hear your side and give a chance for things to be sorted out, although the climate of distortion was such that this was defeated ... '. It was indeed a 'climate of distortion' that provided the opportunity to prevent any further 'misuses' of education facilities in order to expose conditions and practices that have allegedly become obsolete.

References

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8. The 'ghost train'.
9. The 'ghost train'.
10. This order primarily relates to correspondence and prohibits the inclusion of various information relating to any matter intended for possible publication.
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APPENDIX 2 THE HUMAN VALUES IN HEALTH CARE FORUM

The Human Values in Health Care Forum originated from a consideration of the implications of the part played by the German medical profession in the activities of the Nazi state before and during the Second World War. This included the euthanasia programme for the unfit; human experimentation in concentration camps; and genocide against the Jewish people and others. The founders of the Forum believe that no person or state is immune from subversion of professional ethics. This may lead to inhumane behaviour and failure to observe the highest respect for the value of the individual human being.

AIMS and OBJECTIVES

The central objective of the Forum is to preserve and promote human values in the practice of modern health care. The Forum endeavours to study contemporary situations and events in which human values in the practice of health care are, have been or may be threatened, subverted, neglected or overridden.

The Forum promotes discussions, lectures, conferences and publications and may issue consensus statements on matters of general concern consistent with its aims and objectives.

MEMBERSHIP

Membership is open to anyone with an interest in the broad field of health care who affirms their acceptance of the objectives of the Forum and on payment of the current subscription. Members receive information about all activities and publications of the Forum and a copy of the constitution, The Forum is currently supported by a grant from Gresham College.

Further enquiries and requests for a membership application form should be made to:-

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