special articles

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The experience of being a guest medical inspector with the Prison Inspectorate

Health care for prisoners suffering from mental disorders is a subject that not only has a direct impact on my clinical work as a forensic psychiatrist, but it is also a particular research interest of mine. Therefore, I was delighted when the opportunity arose to shadow Dr John Reed (Medical Inspector) for 3 days during a full, announced inspection of Leicester prison in October 1998. Since then I have been invited back as a guest medical inspector to assist with the inspection of two large prisons: HMP Liverpool and HMP Wandsworth (London).

Role of the Prison Inspectorate

The Prison Inspectorate was established in 1980 as a result of the recommendations of the May Committee of Enquiry into the United Kingdom Prison Services. The principal duty of the chief inspector (currently Sir David Ramsbotham) and his team is to inspect prisons in England and Wales and report to the Secretary of State on the conditions and treatment of prisoners therein (Prison Act 1952). Her Majesty's Inspectorate of Prisons is an independent body, but many of the 20 or more regular members of staff have past experience in the prison service at governor grade. Specialist inspectors are also employed to provide an inspection team with additional expertise in areas such as health care, pharmacy, education and buildings.

Prison inspection programme

All prisons, remand centres, young offender institutions and Home Office detention centres in England and Wales are subject to inclusion in the programme of inspections. The Inspectorate also visits, by invitation, similar institutions in Northern Ireland and certain Crown Dependencies. Approximately 20 full, announced inspections and a similar number of unannounced and follow-up inspections take place each year. The aim is to inspect each establishment once every 5 years, although in the intervening period it may be subject to a follow-up inspection (to ascertain whether recommendations made to address serious problems identified during a recent inspection have been acted on), or an unannounced inspection, arranged as a result of serious concerns being raised. Every inspection generates a written report: this is sent to the Home Secretary and the Prison Service within 3 months of the inspection. These reports, annual reports and thematic reviews undertaken by the Prison Inspectorate are available from the Home Office Publications Department (Room 856, 50 Queen Anne's Gate, London SW1H 9AT). They are also published on the Internet (http://www.homeoffice.gov.uk/hmipris/hmipris.htm).

Format of a full inspection

The Inspectorate works to a set of 'expectations' of the services in establishments. The inspection of health care is based on assessments of the scope and quality of care provided against the standards set by the prison service in Prison Rules, Standing Order 13 and the nine Health Care Standards, and, for areas not covered by these, standards equivalent to those found in the NHS.

The size and composition of an inspection team is largely determined by the nature, size and facilities of the establishment to be inspected. Each team member is supplied in advance with a briefing pack containing details of the prison concerned and supplementary information that will help to guide the inspection: this may include previous inspection reports, recent letters of complaint and reports from other organisations, such as the Board of Visitors.

On arrival at the prison gate on the first day of the inspection, team members draw keys and a brief meeting is held with the Governor to outline the inspection programme. A room suitable as a base for the inspection team is found and after an initial briefing the team disperses and begins the inspection. Although it is inevitable that some disruption will be caused, especially if the inspection is unannounced, inspectors try to interfere with procedure as little as possible, so that the normal daily routine of the prison can be observed. There is much to be done and the team works from early morning until late afternoon or early evening; night visits are also carried out. Briefing and update meetings are held at the beginning of each day, over a sandwich lunch and again

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before leaving the prison each evening. Information is gathered by inspecting prison facilities, observing routines, examining records and, most important, by talking to staff and prisoners. The inspection programme evolves as it progresses; a core inspection is carried out, but exchange of information between inspectors means that areas of the prison where problems are apparent come under particular scrutiny.

My experience of prison inspections

Many psychiatrists who visit prisons seldom venture beyond the confines of the prison health care centre and few spend time in the main accommodation areas (wings or house blocks), where most of the psychiatric morbidity in prisons is found.

Perhaps the most striking difference I noticed as a guest inspector, compared to being a visiting psychiatrist or a prison researcher, was having unhindered access to prisoners and prison facilities. As an inspector there is no delay at the gate and no wait for an escort; access to prisoners is not restricted to the hours of 09.30–11.00 and 14.00–15.30, and I have yet to be told I cannot see a prisoner because staff shortages mean he or she cannot be released from his or her cell.

The vast majority of prison staff I encountered during inspections were friendly and helpful: most were willing to talk about problems in the prison, and the difficulties they described were almost always apparent on closer inspection. A few members of staff seemed particularly unnerved by the presence of inspectors, but most seemed to go about their work as usual. Only a few staff members were frankly obstructive; those working in health care tended to come from a prison service rather than an NHS background, had inflexible attitudes and strongly defended inappropriate working practices. For example, in one prisons one-quarter of the inmate medical records belonging to patients located on the two landings in the health care centre, housing predominantly inmates suffering from mental disorders, contained recent entries directly referring to a significant risk of self-harm or suicide. None of these patients had had an F2052SH opened (a file that should be opened in the event of concerns about a prisoner being at risk of self-harm). Although health care staff were aware of the circumstances under which an F2052SH file should be created, when I asked about the patients in question, I was told that it was up to staff to use clinical judgement to determine whether the prisoner was threatening self-harm to manipulate staff, and that it was not always appropriate to open an F2052SH, even when there was a significant chance of self-harm.

All three prisons I visited had Level 3 health care facilities, that is, an in-patient health care centre with 24-hour staffing. Inspection of these facilities confirmed my view that prisoners suffering from serious mental disorder are at significant risk in prison, the prison environment is detrimental to their mental health and such individuals should be treated in appropriately secure NHS psychiatric facilities. The layout of all three health care centres was such that patients could not be adequately observed. Outside exercise facilities for patients were poor, offering no shade to prevent those on antipsychotic medication becoming sunburnt. Furthermore, patients were locked in their rooms for up to 22 hours per day, making health care centre regimes among the most restrictive in the prison.

One of the primary functions of a health care centre in a local prison such as Leicester, Liverpool or Wandsworth is to accommodate prisoners suffering from serious mental disorders pending transfer to NHS facilities. However, in keeping with my research experience (Birmingham *et al*, 1996, 1998) I soon discovered that many prisoners suffering from serious mental disorders were located in the main accommodation area of these prisons. I asked prison officers in these areas of Wandsworth and Liverpool prisons to identify prisoners whom they considered to be odd, strange or behaviourally disturbed. The officers in question had no difficulty identifying plenty of individuals meeting this description, and using a brief clinical interview I found clear signs of mental illness in two-thirds of these prisoners: most were floridly psychotic. Subsequent inspection of their prison medical records revealed that prison health care staff were not aware of any significant mental health problems in the majority of cases (Birmingham, 1999).

In conclusion, spending time with the Prison Inspectorate has been a very rewarding experience, and although prison inspection is a serious business, working alongside other members of the inspection team proved to be good fun. I have had considerable experience with prisoners, but my involvement with the Inspectorate gave me valuable insights into the difficulties in delivering adequate health care in prisons. The picture that unfolded during the inspection of each of the prisons I visited with the Inspectorate reinforced my belief that the prison system in this country is overflowing with people suffering from mental disorders because serious inadequacies in our mental health services allow them to gravitate there.

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