Committee for Justice

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Improving Health in the Criminal Justice System: Northern Ireland Prison Service

1 December 2016
NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Paul Frew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Mr Alex Attwood
Ms Clare Bailey
Mr Doug Beattie
Mr Sammy Douglas
Mr Declan Kearney
Mr Trevor Lunn
Mr Pat Sheehan

Witnesses:
Ms Julie Anderson Northern Ireland Prison Service
Mr Phil Wragg Northern Ireland Prison Service

The Chairperson (Mr Frew): I welcome Julie Anderson, head of interventions and healthcare, Northern Ireland Prison Service, to the meeting. You are very welcome, Julie. Phil, thanks for staying for this second session, which is being recorded. The Hansard report will be published on the Committee web page. Phil, are you starting?

Mr Phil Wragg (Northern Ireland Prison Service): I will make the statement. Thank you, Mr Chairman, for your welcome. I am grateful for the opportunity to brief you today. Members requested an update on the consultation on ‘Improving Health within the Criminal Justice System’ draft strategy and action plan.

By way of background, officials from the Departments of Health and Justice worked together to develop the draft strategy and action plan, which we shared with the Committee in March, before it was issued for wider public consultation. The aim of the strategy is to ensure that children, young people and adults who are in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour. It covers the health and social care needs of people at all stages of the criminal justice journey in Northern Ireland. It is not simply about prison.

The public consultation was launched on 24 March 2016 and concluded on 20 June 2016. To reach as many interested parties as possible, 800 emails and letters were issued to the voluntary and community sector — the third sector; statutory, public and professional bodies; and the press. As part of the engagement activity, we held two stakeholder events on 18 May, which were attended by 43 people. In addition to the feedback received during these events, we received 30 formal responses. In response to feedback, we arranged a further engagement event at the Juvenile Justice Centre on 1 September to take the views of the young service users. Feedback from stakeholder events broadly
mirrored the individual responses received. There was a clear endorsement of the draft strategy and action plan.

Key things arising from the consultation were as follows: there needs to be a clear picture of the health needs of people who are engaging in the criminal justice system; the over-representation of looked-after children in the criminal justice system needs to be referenced; although acknowledged that they are not part of this strategy, early intervention and prevention strategies are key to longer-term reduction in reoffending; the voluntary and community sector is keen to be involved in the implementation of the strategy; and joined-up working between the Departments, and the appropriate sharing of information, would benefit all stakeholders and service users.

There was broad agreement that the priorities, issues and groups identified in the draft strategy were the right ones, with additional issues and groups put forward to be considered for inclusion. Many respondents commented on the need for specific targets and completion dates to be specified in the associated action plan. Following the consultation period, both Departments considered the responses and agreed amendments in response to feedback to the draft strategy and the action plan.

We would like to invite the Committee to consider the consultation analysis report and provide comments on the revised draft strategy and action plan. Health colleagues will provide an update to the Committee for Health and invite responses. Once we receive any comments, we will consider them and submit the final revised draft for both Ministers' approval, and onward submission to the Executive for final approval will be in the new year.

Thank you for giving us the opportunity to speak this afternoon. We welcome any questions on the key themes that I highlighted.

The Chairperson (Mr Frew): Thank you very much, Phil. I appreciate you being concise and clear. The first question begging to be asked is this: why has it taken so long to get here? The review first recommended a strategy and action plan in October 2011, yet we are only now at the end of the consultation. What went wrong, or where were the failings?

Mr Wragg: That is a good question. Unfortunately, I was not around at the time, so I cannot provide a lot of data on why it has taken the length of time that it has. As I am not able to stand over that and provide the detail, all I can say now is that we have gripped this and developed the consultation this year. We are moving forward at pace. I do not know whether you have any detail about what happened previously, Julie.

Ms Julie Anderson (Northern Ireland Prison Service): Like Phil, I was not there when it kicked off. What I can say is that an awful lot of work has been done by both Departments to engage with service users and the third sector and to build as many views as we could into the process to get us to where we are. This is a complex strategy. As Phil said, it is not just about prisons. The original Owers recommendation was about prisons, but it has been widened to take into account the wider justice community. It is a wide-ranging strategy, and it has taken quite a bit of time to get it to this point.

The Chairperson (Mr Frew): We have moved on from 2011. The Minister announced on Monday 21 November, when she made her statement on the recent deaths, that she will develop a community response plan — the same model as people have on the outside — review the suicide and self-harm policy and provide a joint healthcare and criminal justice strategy covering the health and social care needs of people at all stages in the criminal justice journey. All that is ongoing. How does it all wed together?

Ms Julie Anderson: If you look at the associated action plan in the strategy, you will see under, "Health promotion and ill-health prevention", for example, that there are actions in which there is a requirement to have in place the substance misuse strategy and the suicide and self-harm prevention strategy. Both are joint documents between the Department of Health and the Prison Service. Bearing in mind that it is a five-year strategy that it is due to kick off from 2017, it is appropriate that we are already working on the actions that we have highlighted, albeit that they have not been formalised and the strategy does not yet have formal approval. The Departments are working together: for example, the Prison Service and the South Eastern Trust have been working together.

You mentioned the community response plan. Prison community response planning has already started, on foot of the two recent suicides. We have had two meetings over the last two weeks to look
at what the response in the prison has been. The prison community response plan will be one of the actions that falls out of the suicide and self-harm prevention strategy that is being developed.

Mr Wragg: I will talk a bit more in depth about health. We are hearing lots about mental health, and appropriately so, as well as the vulnerabilities of individuals who come into the criminal justice sector. Health is much wider than that. We need to be able to demonstrate that we are aware of the different types of people who come into prison from the community. For instance, we have an ageing population coming into our prisons, so we must be aware of dementia and physical health concerns. We need to be able to mirror what is occurring in the community in respect of health interventions and provide that to the people in our prisons for whom we have a duty of care to manage. That is part of this strategy, too. The consultation is not simply about mental health or vulnerable people; it is about the complete spectrum of individuals whom we will encounter in our criminal justice system, and the different concerns, physically and mentally, that they present, making sure that we are focused on them.

The Chairperson (Mr Frew): Thank you very much. We know that there are recruitment issues on the Prison Service side and the health side. With all due respect, a prison is probably not the most glamorous posting for a nurse. That said, we know, having heard from nurses at the Committee, that there is still a real passion to assist and to administer first aid and healthcare. How will we retain good staffing levels for our prison population through the health service?

Mr Wragg: I think that we suffer from a "behind these prison walls" mentality. People do not know what goes on but can only imagine. They see what they see on television, and they do not take the step to understand what really goes on behind the prison wall. That is our problem. That is our fault. We need to make working in prisons an exciting opportunity for individuals to work with some of the most challenging people from the community, and there can be fantastic rewards. We are starting to see with South Eastern Trust colleagues that people are choosing to have health as a career and that they are enjoying working in prisons. It is not what they thought it was going to be, and the opportunities for them are significant. There needs to be an ongoing advertising campaign, and we need to have opportunities for people to go into an establishment and see the working conditions before they maybe submit an application form. They could maybe then say that they are interested in that and that they would like to sign up for it. Until we break down those jaundiced opinions of what prisons are about and what it must be like to work in a prison, as we have seen with our staff in the Northern Ireland Prison Service, we will not start to be able to get people to come through the door voluntarily. We need to help them get through the door.

Ms J Anderson: There is a focus in the strategy on workforce development. In fact, one of the seven sections in the action plan is around workforce development, and it looks at the recruitment training as well as the learning and development and training and support that staff get, both from the criminal justice perspective and from the health side.

The Chairperson (Mr Frew): Sammy Douglas, I apologise sincerely for ignoring you earlier, and I offer you the opportunity to go first, if you have any questions.

Mr Douglas: That sounds like an apology. Thank you, Chair. Thanks, Julie, for staying. I saw you outside, and I am sure that your head is turned.

In the previous discussion, the Minister reminded us that 75% of prisoners have mental health problems. Phil, you mentioned the community and voluntary organisations. Can you tell us a bit about the discussions with them and the sorts of organisations that you are talking about?

Ms J Anderson: I will come in on that one. We had two stakeholder engagement events, and 14 voluntary sector organisations came to the two events. We had the Quakers, Start360, Children in NI (CiNI), Relate, the Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO), Nexus, Cruise Bereavement Care, Include Youth, Contact NI, Mencap and Women's Aid. We had a very broad range across the spectrum, both for young people and for adults there. We received 30 formal written responses to the consultation, and, in those responses, we had further groups that responded in writing but which did not attend the stakeholder events. We got responses from the Children’s Law Centre, MindWise, Brain Injury Matters, Voice of Young People in Care, Positive Futures and the British Red Cross. Taking those with the formal responses that we received in the consultation events, we did have a good broad range of views expressed. I think that it is worth highlighting again the fact that it came across very clearly in the consultation that there was broad support for what we were trying to do across the two Departments with this strategy.
Mr Douglas: Thanks very much, Julie.

Ms Bailey: Thank you very much for coming in. I notice that this report goes back to 2011. One of the strategic aims coming out from it specifies management's role. I notice too that the CJINI report that was launched last week identifies a bit of an issue between the management of NIPS and the prison staff. Do you have a strategy in place currently? It is good to hear that, in the draft strategy, there is a place for workforce development and, I imagine, a lot of ongoing training. What happens at the minute? How is a prison officer taught to deal with prisoners? The report identified that a lot of the prison officers still carry fear or still say that they are afraid of a lot of the prisoners.

Ms J Anderson: Starting off with the recruit training that we deliver, our recruit training package is accredited through the University of Ulster, and it consists of a nine-week induction period, but then there is a further development period of 18 months to two years in total. That culminates in a formal level-4 qualification. Now, within the nine-week induction period, training is balanced between day-job modules that develop them in the practical aspects that they need to take forward on the job, such as handcuffing and completing journals — those sorts of day-to-day activities — with a number of other modules. We have development modules. We also have the likes of emergency first aid. We have safeTALK training. We complete applied suicide intervention skills training (ASIST). They receive mental health awareness. They receive training in personality disorder. They receive modules across a number of areas which help them in developing the skills that they come into the service with to be able to deal with the vulnerable and challenging people they will come into contact with.

Ms Bailey: In jobs that I have had in the past, a lot of training had to be done; it was mandatory. You cannot work with vulnerable people without having done those accredited training programmes. Once that initial training is done and they begin working, is there follow-on training? Is there current development or a current standard? Is there a strategy for the workforce in prisons?

Mr Wragg: As regards how we develop staff, there is no additional training in respect of how they deal with individuals unless there is something specific that we feel that they need to be trained in. Being a prison officer is not an easy job, but the training that Julie has identified equips people well to be prison officers. Much of what they have to do then is to deal with individuals as they present on the landing. They are equipped with the necessary skills to make the best choices —

Ms Bailey: In just those nine weeks?

Mr Wragg: Well, it is nine weeks plus ongoing training while they are in place on the landings. They work with their peers and senior officer to ensure that the decisions that they make are right and correct. We do not throw somebody in after nine weeks and say, "Get on with it".

Ms Bailey: What is that ongoing training?

Mr Wragg: They are on probation for a period of 12 months and will be assisted throughout their time on probation. A lot of it is through their work colleagues [Inaudible.] and also with their senior officers. If we found that somebody was not making the right decisions or was concerned about working with those prisoners, we would not allow them to continue doing that. We would take them out. Normally, we would see that in the first few weeks of somebody's going live. It could be the case that we need to refocus on some of their training or even put additional training in place to make sure that they are safe to operate on the landings. Normally, most people pick it up over a period. From working with their colleagues and dealing with the training that they have had, they are very competent, capable prison officers.

Mr Sheehan: Thanks for your presentation. I have some issues with workforce development. I have a general question. What has changed in the training for a prison officer now compared with, say, 10 or 15 years ago? I would also like to hear about any changes that have been made to healthcare provision in the light of the recent reports from the prisoner ombudsman and CJJI. I know that the South Eastern Trust is the health provider. Is there tension in your relationship with the trust? It seems that, on the face of it, to outsiders looking in, there appears to be some tension about who has responsibility for different aspects of duty of care to prisoners. Have there been changes in healthcare provision? Are they big changes or just cosmetic changes? Can you also deal with the issue of training prison officers?
Mr Wragg: I hope that you will identify that what we do is not cosmetic. When we make changes, they need to be well thought through, and we need to make those changes not for change's sake but where there is a definite need to put something different in place.

We have a very good working relationship with the South Eastern Trust and are now working together to develop how we move the organisation forward. We have had to arrive at this point by understanding each other's business. Our businesses are different. We have had to agree that there is an overlap in how we operate; and it is in that overlap that we recognise we work at our best together. I have an incredibly good relationship with the chief executive of the South Eastern Trust and his top team. We start our work on the review, that we have already talked about today, in the week commencing 12 December. I had a conversation with him yesterday about how we are going to take that forward. I have no problems there.

Yesterday, I was in Maghaberry, and I was talking to the governor about the unfortunate death in custody and how the establishment was operating. He went to great lengths to tell me about how his relationship with the senior health providers in the establishment is good and how they attend his morning operational meetings. There is a very good, purposeful engagement in respect of his management of the establishment and their management of health within it.

Has prison officer training changed? I am really pleased to announce that it has. The change goes back 10 or 15 years, beyond prison officer training to how we have recruited people into our organisation. We have a very eclectic group of people coming into our organisation now who are from a different range of backgrounds, male and female and all different ages. We have a group that, we would say, absolutely represents the community. Our training has been tailored to meet the needs of a duty of care that we have to the prisoners and the different styles, conditions and concerns that they bring to us within custody. So it is different. Yes, [inaudible.] Julie, you have done a lot on prison officer training. You might want to say something about that.

Ms J Anderson: The training 10 years ago was very focused on security and the day job. Recommendation 26 of the prison review team (PRT) report, the Owers report, focused on the training that was delivered to prison officers, and it was very clear that it was not meeting the needs of a modern service. I talked about some of the modules that are now included in the recruit training programme. We have a focus on the expectations document, for example. There is a module on that. That is included in the first week of training, when recruits arrive in the service. It is made very clear what the expectations are in the wider sense of their role in a modern prison service. We have a balance between skills training and the practical day job, because that is still important. It is important to keep people safe and in a decent environment. They need to know how to do that for their safety and for the safety of the people in their care. However, we keep that balance as well, between skills and the practical piece, to ensure that they are well equipped to do the job.

Mr Wragg: There is one point that I want to make. We have a very professional, diligent, competent group of prison officers across our organisation who do a very difficult and complex job. That could be a person who has served 30 years in our organisation or one who has served three weeks in it. What has changed is that we are developing the organisation, and we are bringing our staff with us. The skills that somebody had 30 years ago were absolutely appropriate for that time; I do not denounce them. However, the individuals that we have in our organisation are reflective enough to realise that we are on an agenda of change. I talked about modernisation earlier today and said that we take our team, our staff, with us. We build on the skill set of every member of staff to ensure that they are well equipped to do the job.

Ms J Anderson: Let me just pick up on that. As part of the work in the organisation we did following the Owers report, we developed new programmes for existing staff so that it was not just about training new people coming into the organisation. Main grade officers and senior officers received training as well.

Mr Sheehan: Within that training, is there anything to help develop the ability to spot vulnerable individuals; for example, people who might self-harm — people with mental health issues?
Ms J Anderson: Mental health awareness is included, as is supporting prisoners at risk (SPAR) and autism awareness. All those sorts of elements are included in the recruit training programme. Our prison officers are not, nor will they ever be, clinicians. They are not there to diagnose people. However, it is important that when they see challenging behaviours, they can understand something about what might be behind those behaviours and are able to choose the response that is appropriate to manage them.

Mr Sheehan: What is the policy on control and restraint?

Mr Wragg: I will come back to that in a second, but I just want to go back to the point about spotting vulnerabilities. We have heard lots about mental health statistics — 75% suffering from mental health issues — and on substance abuse. I will always go back and say that the number of occasions throughout a working year on which my staff identify people at risk is significant, and they get it right. They are quick to point out where there is a need for intervention. Yes, we have had three tragic deaths in the last five weeks, but we have saved many others in the past year. Our staff are spotting people whom they identify as being potentially in crisis — perhaps they are brand new in custody and have never been to prison before, or maybe they have been in prison many times. Our work starts when that vehicle arrives at the gate and it does not stop. Those staff are working tirelessly, 24 hours a day, seven days a week, to make sure that people are safe in custody. I am sorry; what was your question again?

Mr Sheehan: It was about control and restraint.

Mr Wragg: What in particular about control and restraint?

Mr Sheehan: I was at a conference last week — Alex was there too — and I was listening to Joe Rafferty, who is the chief executive of Mersey Care NHS Foundation Trust. He spoke about the new policies that Mersey Care has introduced with regard to control and restraint in ordinary hospitals and secure hospitals. He named one hospital in particular, which was Ashworth Hospital. Except in the most extreme circumstances, the staff in that hospital do not restrain patients or prisoners. I wonder what the policy is here, because it seems to have had a very positive impact in Mersey Care.

Mr Wragg: We employ the use of force, as we would describe it, only in exceptional circumstances and only for a period of time where it is warranted. We want to de-escalate situations; we do not want to automatically default to a use-of-force position. We would rather talk our way through a particular situation if we find ourselves on a landing or in a cell. If we do have to employ use of force, then the supervisory staff will ensure that de-escalation occurs and that a nurse is present when we use force. De-escalation occurs as quickly as it is safely and reasonably possible to do so. We do not want to leave somebody under the use of force. We are fully aware of excited delirium and positional asphyxia, etc, so we want to be able to take somebody out of that use-of-force situation as quickly as possible and de-escalate.

Mr Sheehan: So de-escalation is the first option.

Ms J Anderson: It is the default position.

Mr Wragg: The position is, first, that we should not get to a use-of-force situation. It is an escalatory process. If we have to use force, it is because all other options have failed. As soon as we are using force, we want to de-escalate it as quickly as we can. We should be starting to think straight away about what a de-escalation process demands.

Mr Attwood: My question is a variation on the same theme. You seem to be giving the Committee a very high level of reassurance that the training that prison officers undergo, initially and ongoing, enables them to respond and, as best as possible, to identify a person in custody who may be, for example, critically self-harming or at suicide risk. Are you satisfied that the level of training, initially and ongoing, enables your staff to respond effectively? You made the point that there have been tragic cases over the last number of weeks. Over the last year, however, a lot of people have been identified and have been given support, if not saved. Are you satisfied that the systems and training that you have in place at the moment are such that your people are best trained and best placed to help to identify and deal with those issues and coordinate with the health side?
Mr Wragg: I think that we are travelling on a journey. We are on a learning journey that says that we will never be completely satisfied that our training meets the needs of what is occurring in the community. That is why we are working with other agencies to ensure that we are learning from what is occurring and incorporating that into how we develop training for prison officers and whether there is a need to incorporate ongoing training if something comes to our attention. At present, and since I have been in Northern Ireland, yes, I am satisfied that the training meets the needs. My staff spot and deal appropriately with people who come into custody, and that happens because staff are trained to identify those needs and concerns.

Mr Attwood: The Minister gave a reply a couple of weeks ago in the Assembly that the review, which has now commenced, will involve people with a community background. It is not just the professionals, the prison staff and the qualified health people but people who — this might be relevant given what you said — may know what is going on in the community. She gave reassurance that people like that — we could name them; a lot of them were at the conference that Pat referred to — will be members of the review so that we can get their best wisdom as well.

Mr Wragg: Yes, I want to go one step further and say that we would like to use life experiences of people who have either been in prison and are now back out in the community or people who are in prison now. We need to get to the bottom of how people can see what we have done and see what the effect of being in prison — or the effects of being released back into the community without the engagement from us while they have been in prison — really feels like. We will be able to take the learning from those people into our review. That is particularly how we will begin to get it right.

Mr Attwood: It would be useful to get a list, in due course, of the members of the review.

The Chairperson (Mr Frew): OK. One of the principles of the strategy is providing the right care in the right place at the right time. It sounds very good, and it is exactly what is meant to happen. There is then making sure that every prisoner has the same access to the health service as everyone else. We think that that is what should happen. If it is in the action plan, where is the pressure being applied to make sure that it happens in a timely way?

Ms J Anderson: In terms of the action plan or from day to day?

The Chairperson (Mr Frew): Both. Obviously, you want your action plan to inform and make sure that your day-to-day work is happening. How can you guarantee the Committee that that will be taken forward in a five-year action plan that has no dates and times? There will be a monitoring group.

Ms J Anderson: The steering group will become the implementation group. I suppose that, like any high-level strategy, the action plan that sits under the strategy is intended to cover the first three years. It is time-bound to the extent that it has to be delivered, and there is a commitment that the actions that are specified in that action plan will be delivered within that three-year period. The intention is that, in year 3 of that action plan, the action plan will be refreshed and a new action plan will be developed for delivery in years 4 and 5 of the strategy. The intention is that, for the actions, delivery implementation plans will be drafted by whoever has lead for a particular action, and that is where you will see the targets, the completion dates and the timescales that will follow at the next level under that implementation plan.

The Chairperson (Mr Frew): Sounds like process. Usually what we find in government circles is that things are processed away or processed out. Can we be assured that that is not the case in this regard?

Mr Wragg: We are post-reform now. We sat in front of the Committee in March of this year and said that we were post-reform. We embarked on the agenda of modernisation. This fits absolutely with modernisation. This is about my commitment to this community. This is about a safe, secure and decent organisation, which is fit, proper and able to meet the needs of those who come from society, often very broken people for whom we are the first service to start managing their needs. We have a commitment to a safer Northern Ireland, and that starts for us when the person arrives at the gate. We would like to be ahead of that. We would like to start doing work in the community with people who have community-based punishments etc. That is something we are eager to get into soon.

The modernisation agenda is a five-year agenda. It encompasses many things. Part of it is about the core day; it is about life in the establishment. Our commitment is to get this right — first time, on time
and every time — because we want a stabilised population in our establishments whose physical and mental health needs are properly met, whose vulnerabilities are properly understood and who are signposted both in custody and also back out into the community with no breakdown in communication. There is no point in us doing lots of very intensive work within our walls if the same level of intensity is not continued when they get out. That is my commitment to you in this Committee.

The Chairperson (Mr Frew): Thank you. I will bring you right back from strategy to the daily nitty-gritty. I ask this question because I genuinely do not know: how does a prisoner access a GP?

Mr Wragg: Far more quickly than for you or I, generally. [Laughter.] A prisoner would self-refer to one of our clinicians or nurses on their wing in the accommodation unit. They would be triaged at that point. They could turn up with a common cold, and they would be advised how that will be dealt with. If there was a need for an individual to see a GP, they would be put on a list of prisoners, and they are then seen very quickly. I cannot give you the timescale, but a person would certainly be seen by a GP within two or three working days.

The Chairperson (Mr Frew): Is there an in-house GP, or is it the same GP?

Mr Wragg: More often than not, it is the same GPs who are contracted by the South Eastern Trust to work in the establishment. We do not have groups of locums coming in and out. We do not get that level of inconsistency. More often than not, it is the same people.

The Chairperson (Mr Frew): There are no further questions at this point. Phil, you have had a marathon session. Thank you very much for your time; I know that you are all very busy people, and I appreciate your time.