Perrie Lecture: Lessons for the Prison Service from the Mid Staffs Inquiry

Nick Hardwick is HM Chief Inspector of Prisons

Contraction in an age of expansion is an intriguing theme: what exactly has been contracting and what expanding? Essentially, it seems to me, it boils down to prisons being expected to do more with less.

Prisons are pretty risky organisations, in fact, you might say that their business is to manage risk on behalf of society. So, I don't think it is very contentious to say that if we are asking organisations that already manage significant risk, to do more with less, it would be only sensible to monitor very carefully whether a consequence of that, is the level of risk increasing to unacceptable levels. But how to do that? No doubt individual prisons, NOMS, the Ministry of Justice, all have sophisticated systems in place to monitor and manage risk, but I want to look at it through a different prism.

I was at an inspiring lecture recently by Robert Francis QC, who conducted the inquiry into the care provided by Mid Staffordshire NHS Foundation Trust – 'The Mid Staffs Inquiry'[1]. Mid Staffs failed with shocking, distressing consequences for patients and their families – and this was despite the very sophisticated systems the NHS has in place to manage risk. I want to consider what lessons the Mid Staffs Inquiry has for a prison service being asked to do more with less. I don't want to make simplistic comparisons – but we would want to be confident, would we not, that there is not a Her Majesty's Prison Mid-Staffordshire out there somewhere?

I should insert a disclaimer here. This is my interpretation of how what Robert Francis said applies to prisons. If you want to know what he thinks, read the report. Indeed, I urge you to do that.

The press statement with which Robert Frances introduced his report begins like this.

> *"The final report into the care provided by Mid Staffordshire NHS Foundation Trust was published today. The Inquiry Chairman, Robert Francis QC, concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care."*[2]

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[1] Robert Francis QC; Mid Staffordshire NHS Foundation Trust Public Inquiry

[2] Robert Francis QC; Press release: Final Report Of The Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust

What allowed that to happen? When I heard Robert Francis speak, he opened his remarks with this quote from Florence Nightingale:

> *"'What can't be cured must be endured' is the very worst and most dangerous maxim for a nurse which ever was made. Patience and resignation in her are but other words for carelessness and indifference – contemptible, if in regard to herself; culpable; if in regard to her sick".*[3]

Swap 'patients' for 'prisoners', 'the prison' for the 'the trust, 'prison governors and officers' for 'nurses' and does not that send a spasm of recognition through you?

Don't respond to this with a shrug that a prison's responsibilities to prisoners are so different from those of a hospital to its patients that somehow it does not apply. Take from it that if this can happen in a hospital where the responsibility to provide care is unambiguous, how much more carefully do we have to guard against it in a prison. Now, to be absolutely clear, I am not saying the conditions that existed in Mid Staffs exist in any prison I know. What I am saying is that it is a risk we should guard against and I think there is some evidence that it is a growing risk.

This is a summary of our inspection findings for 2012/13. It shows the rolling annual average of our healthy prison assessments as the year progresses. It shows a decline for the outcomes for prisoners we have reported in almost all areas over the year.[4]

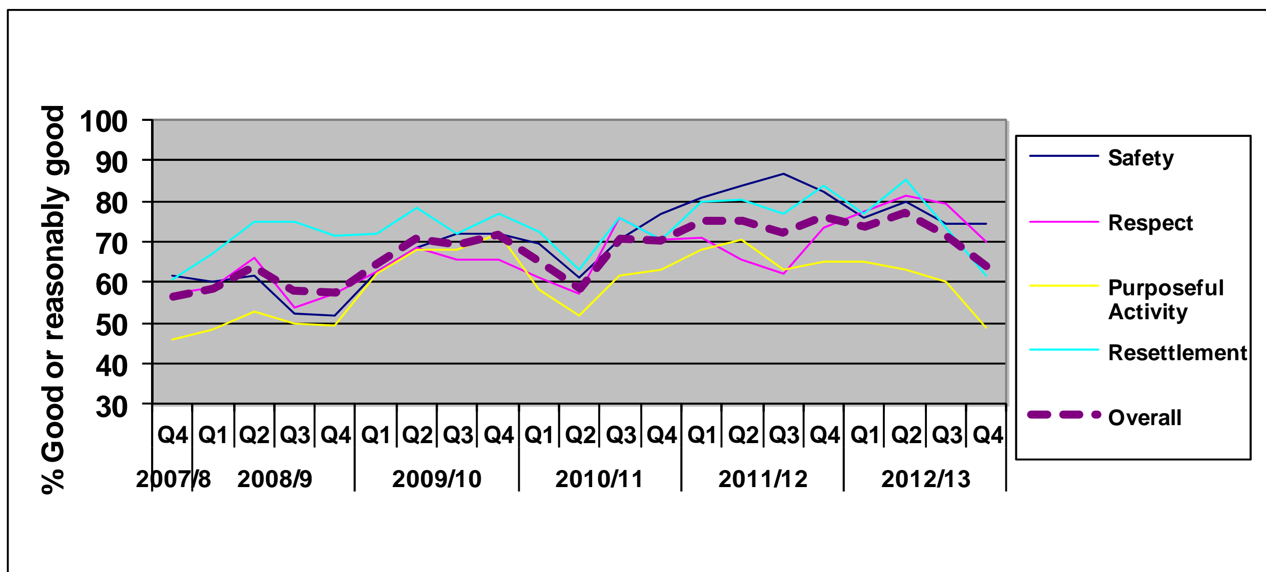

Figure 1 HMI Prisons healthy prison assessments - rolling annual averages

There might be a number of reasons for this to do with our methodology, or the inspection process itself. Perhaps our judgements are getting harsher. Perhaps our

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[3] Robert Francis QC, King's Fund Conference 27 February 2013 Lessons from Stafford quotes: from Florence Nightingale; Notes on Nursing 1860 Pages 92-93'

[4] HMI Prisons. Rolling average of reported inspection outcomes 2012/13

risk assessment processes are getting better so we are inspecting the most problematic places more regularly. No doubt, lots of people will want to explain it in those terms. But hold this thought. Perhaps the reason for this decline in outcomes we recorded in our inspections last year is the most obvious one – things really are getting worse.

The role of HM Inspectorate of Prisons

I should briefly explain how the inspectorate works for those who have not had the joys of an inspection. This will help to explain how we obtain the evidence I will use in this article, and secondly, it is important to acknowledge that some of the lessons arising from the Mid Staffs Inquiry were about the failures of the regulators and inspectors.

The modern form of independent prison inspection, it should be remembered, grew out of the response to the prison riots and industrial relations tensions of the 1970s[5]. The Strangeways riot in 1990 led to the creation of the Prisons and Probation Ombudsman and Independent Monitoring Boards in their current form[6]. When the prison system failed, effective inspection, monitoring and complaints systems were seen as an important part of the remedy. The statutory function of the prison inspectorate is to report on 'the treatment of prisoners and the conditions in prisons'. That means we report on outcomes for prisoners, not the management of prisons. That responsibility now extends beyond prisons to Young Offender Institutions, immigration detention, police and courts custody.

In all those areas we assess prisons against the four healthy prison tests below:

Safety	prisoners, even the most vulnerable, are held safely
Respect	prisoners are treated with respect for their human dignity
Purposeful activity	prisoners are able, and expected, to engage in activity that is likely to benefit them
Resettlement	prisoners are prepared for their release into the community and helped to reduce the likelihood of re-offending.[7]

In each area we make an assessment of whether outcomes for prisoners are good, reasonably good, not sufficiently good or poor. To analyse and compare these assessments we give them a numerical value – 'Good' is 4, 'Poor' is 1 etc. Each healthy prison test is underpinned by a set of Expectations or inspection standards that we inspect against and each Expectation has a set of indicators that set out the evidence we will look for to provide assurance the Expectation has been met. These Expectations are referenced against human rights standards and norms. An

[5] The Home Office; Prisons over Two Centuries extracted from the Home Office 1782 to 1982.

[6] The Woolf Report 1991; quoted in Doing Time or using Time: HM Chief Inspector of Prisons January 1993

[7] HMI Prisons: Prison Expectations: Healthy prison tests

important part of how we operate is that we are not auditors checking that prison service policy and procedures are being followed, we are inspecting outcomes against objective, external standards. We carry out about 100 inspections a year and almost all now are unannounced.

When we inspect we come to our judgements on the basis of five main sources of evidence:

- Prisoners surveys
- Discussion with prisoners individually and in groups
- Talking to governors, staff and visitors to the prison
- Examining documents and records and
- Observation

Our role was strengthened when the UK became a signatory to the Optional Protocol to the Convention Against Torture and other cruel, inhuman and degrading treatment or punishment - or OPCAT as its known. OPCAT requires signatory states to establish a system of independent, preventative inspection of all places of detention known as the National Preventative Mechanism or NPM, and the prisons inspectorate is one of the bodies that make up the UK NPM. OPCAT specifies the characteristics an NPM must have:

- It must be independent
- Adequately resourced
- Have access to all places of detention and detainees and to all information
- Be able to conduct interviews with detainees and staff in private
- Make regular visits
- And be able to make recommendations and comment on legislative proposals.[8]

I think those who designed OPCAT had two great insights. The central features of the system are first, that it recognises inspection as a preventative system. The primary purpose is not to catch establishments out doing wrong or detect human rights abuses - but to prevent things going wrong in the first place and prevent those human rights abuses from occurring. Second, it recognises that for the inspection function to be effective, it needs to be independent, and our independence is central to how we work. Sometimes, that independence means we have unwelcome or difficult things to say and OPCAT provides an important safeguard for our ability to do so.

Much of what I have to say in this article is based upon that inspection evidence – I will focus on the evidence of our inspections of adult male prisons – not because other types of custody are not important but because they are a topic in their own right.

[8] Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

As part of looking at the lessons of the Mid Staffs enquiry, I will consider the role of inspection, monitoring and complaints bodies in identifying and managing risk in a system under pressure.

What is contracting and what expanding?

We are all familiar with the idea that the prison population has grown enormously over the last few decades. In June 1993 the prison population stood at 44,246. It peaked in December 2011 at 88,179.[9]

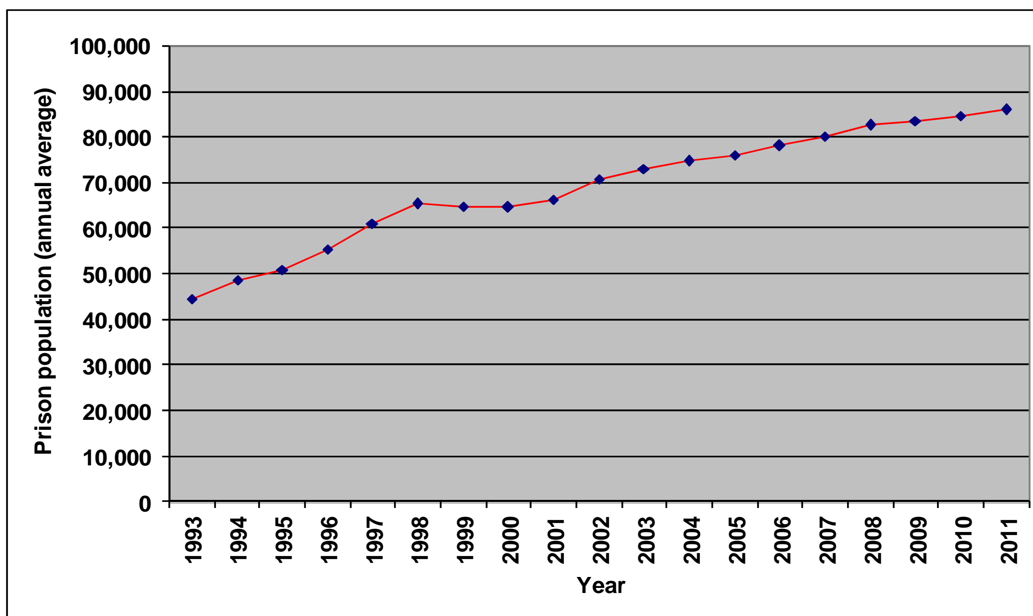

Figure 2 Total prison population 1993 – 2011 by year

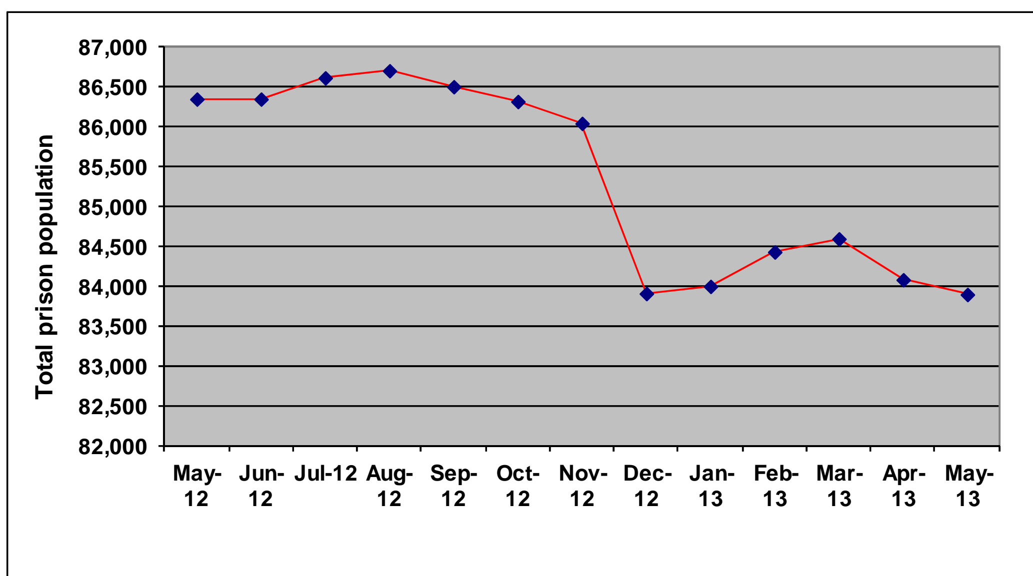

Figure 3 Total prison population 2012/13 by month

[9]http://webarchive.nationalarchives.gov.uk/20130315183909/http://www.justice.gov.uk/downloads/statistics/mojstats/story-prison-population.csv

However, since then it has fallen and stood at 83,897 at the end of Mat 2013. A fall of almost 5%.[10]

So we need to qualify our idea of a continually expanding prison population. It would be right to be cautious about putting too much reliance on the most recent figures but it is fair to say that NOMS' own projections predict a continuing downward trend.

Prison numbers cannot be looked at in isolation. We need to consider them against overall prison capacity and whether the type of prison we have is fit for purpose.

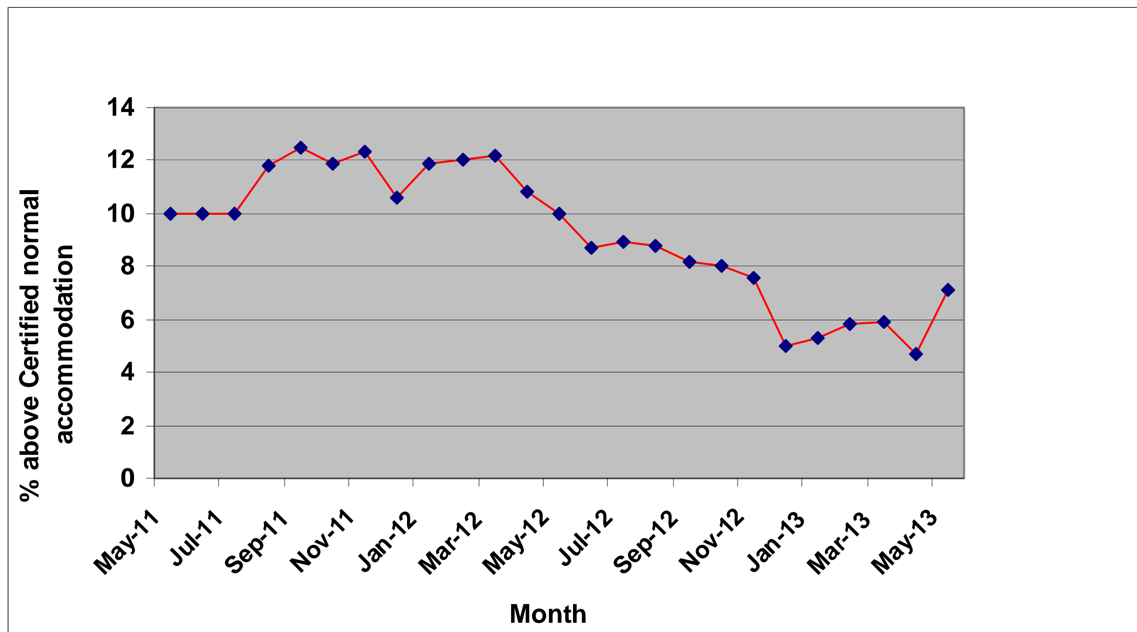

Figure 4 Overcrowding % 2 years to May 2013

In December 2011 the capacity of the prison estate was 78,471 but it had to hold that record number of 88,179 prisoners. It was operating at 12.4% over capacity. At the end of May 2013, the capacity had fallen to 78,347 and prison, and the system held 83,897 prisoners – 7.1% over capacity. Still too high, but less overcrowded than before[11].

In January this year, the government announced the closure of 7 prisons and plans to increase the size of others and build one large 'titan prison'. The prisons announced for closure were Bullwood Hall, Camp Hill, Canterbury, Gloucester, Kingston, Shrewsbury, Shepton Mallet. [12]

Most of these prisons were smaller than the average prison size and some with specialist functions, such as Shepton Mallet and Kingston, which were amongst the best we inspect. But others, like Gloucester, Camp Hill and Canterbury, whilst still

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[10] https://www.gov.uk/government/publications/prison-population-2012

[11] http://d19ylpo4aovc7m.cloudfront.net/fileadmin/howard_league/user/pdf/Prison_watch/Prison_Watch_21.06.2013.pdf

[12] Ministry of Justice: Press release 10 January 2013: Changes to prison capacity announced

small were amongst those about which we had significant concerns, at least in relation to some of their functions.[13]

Establishment	Inspection date	Population	Safety score	Respect score	Purposeful activity score	Resettlement score
Bullwood Hall	03/09/2012	209	4	3	4	2
Camp Hill	21/05/2012	580	2	3	1	2
Canterbury	16/07/2012	299	4	3	4	1
Gloucester	03/07/2012	309	3	2	1	2
Kingston	16/08/2010	195	4	4	3	4
Shepton Mallet	14/06/2010	189	4	4	3	4
Shrewsbury	05/09/2011	333	4	4	3	2

Figure 5 Closed prisons - last HPA scores

There is an argument that larger prisons not only provide economies of scale but can also provide a greater range of opportunities than smaller prisons. Announcing plans to build a titan prison, Chris Grayling, the Justice Secretary said:

> *"If you've got a big centre like that you've got the ability to put good training facilities at the heart of it because it's in all of our interests to make sure that people come out of prison with more education, more skills and they have a better chance of getting a job rather than going back to prison."[14]*

I looked at how we had assessed the ten largest prisons at their most recent inspection.[15] They do not include the very large new Oakwood prison which we have

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[13] HMI Prisons: Inspection reports

[14] Rt Hon Chris Grayling MP, Lord Chancellor and Secretary of State for Justice, quoted by the BBC 10 January 2013

[15] HMI Prisons: Inspection reports

not inspected yet. The results were mixed but it is noteworthy than none of them were good or reasonably good in all the healthy prison tests and they tended to score worst against our purposeful activity test. There might be a number of reasons for that – these are mainly overcrowded local prisons and a large training prison operating at the correct capacity might do better – but I think the onus is on those who propose such a model is to evidence that it will and I do not think they have done so yet.

HEALTHY PRISON ASSESSMENT SCORES							
Establishment	**In-use CNA**	**Population**	**% Over-crowded**	**Safety**	**Respect**	**Purposeful activity**	**Resettle-ment**
Birmingham	1,093	1,413	129%	3	3	2	2
Elmley	943	1,243	132%	3	3	2	3
Forest Bank	1,064	1,316	124%	3	3	2	4
Hewell	1,003	1,203	120%	2	1	2	3
Highpoint	1,259	1,244	99%	3	3	3	2
Northumberland	1,354	1,316	97%	3	3	2	2
Parc	1,170	1,435	123%	3	2	2	4
Pentonville	915	1,262	138%	2	3	2	2
Wands-worth	730	1,218	167%	1	1	2	3
Worm-wood Scrubs	1,170	1,240	106%	3	3	2	3

Figure 6 Largest prison HPA scores

For a more systematic view about the relationship between prison size and prison outcomes, I turned to some work done by one of our excellent researchers, Sam Booth, in 2009 at the time the Labour government was itself planning for the introduction of titan prisons[16]. Her work looked at the characteristics of a prison that was performing 'well' – pretty much equivalent to the 'good' outcomes we use today. Her very thorough and systematic analysis found than prisons with a population of less than 400 were four times more likely to be performing well than a prison with a population of over 800. Other factors were important too – older prisons opened before 1938 for instance were 47% less likely to be performing well than a prison opened from 1978 onwards.

None of this is too surprising. If you pull this together what is says, is that size is not an exact predictor of performance but on the whole, the analysis bears out what common sense would suggest – that as the size of prisons increase, they will be more difficult to run.

Running larger establishments is not the only challenge governors have. They are increasingly commissioners or contract managers, with many of the functions provided by their prison – healthcare, learning, skills and work, resettlement provision and an increasing proportion of support and ancillary functions - provided by contracted providers. As we see sometimes in healthcare or learning and skills for instance, the control the governor has over that provision is tenuous and when things go wrong, the governor's ability to take corrective action is very constrained.

I will give an example from our inspection of HMP Ranby last year[17]. I quote from the introduction to the report:

> *Poor prescribing practice was one element of very poor health care commissioned by NHS South Yorkshire and Bassetlaw.*
>
> *The prison had tried to address this prior to the inspection but without success.*
>
> *The care provided by individual medical staff was good.*
>
> *There were a high number of missed appointments but long waiting lists for an appointment.*
>
> *There was no out of hours service and unqualified prison staff had to judge whether a prisoner who complained of being unwell at night should be taken out of the prison to hospital with all the disruption that entailed, or told to wait until the next morning when a nurse or doctor would be available to see him. In our view, this seriously compromised prisoner safety.*

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[16] HMI Prisons: The prison characteristics that predict prisons being assessed as performing 'well'; a thematic review by HM Chief Inspector of Prisons. Samantha Booth 2009

[17] HMI Prisons: Report on an announced inspection of HMP Ranby (5-9 March 2012) by HM Chief Inspector of Prisons

At the heart of these issues were poor partnership arrangements and the partnership board, which should have provided a forum for sorting them out, had not met for more than six months.

What happened was the governor was at his wits end. Commissioners and providers showed very little knowledge or interest in what was required in the prison with consequences not just for the health of prisoners but also for the wider security of the prison. In my view, the governor had done everything possible he could to resolve the situation.

Despite these challenges, the expectations that prisons should deliver more are growing too. I very much welcome the government's intention to transform rehabilitation services and provide greater support to the many prisoners serving short sentences who now receive very little support at all[18]. Some aspects of the proposed mechanisms for delivering this require further thought – but who can argue with the intention?

It is a fact, however, that the prisons that will bear the greatest responsibility for delivering this are many of the large, overcrowded Victorian prisons with huge churn amongst their populations and that are amongst the most difficult to run. These are the prisons too which will have to deliver changes to the Incentives and Earned Privileges scheme[19] which will particularly affect prisoners when they begin their sentence – and no doubt they are looking forward to implementing the smoking ban when that comes into force next year I believe.[20]

So even if the prison population itself seems to have at least stabilised for the moment, what is certainly expanding are the expectations on prisons and those who work in them – to deliver better outcomes from larger, more complex establishments.

And what is contracting? The resources they have to do it with. The National Audit Office reported in 2012 that NOMS as a whole (that is prison, probation and HQ functions) had to save £884M from their 2010 baseline, 37% of which had to come from HQ.[21] Much of that saving has come from staff. 'Fair and Sustainable' and the benchmarking exercise have significantly reduced the number of officers supervising prisoners and the number of governors and managers supervising officers and staff and the support they all get from HQ.

When the Public Accounts Committee considered the NAO report, the committee recognised NOMS' success in meeting its financial targets despite the challenges it faced but the Chairman, The Rt Hon Margaret Hodge MP said:

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[18] Ministry of Justice: Transforming rehabilitation; A strategy for reform 3 May 2013

[19] Ministry of Justice: Press release 30 April 2013: Toughening up prisoner privileges

[20] See for example Mail on Sunday 3 March 2013

[21] National Audit Office 18 September 2012: Restructuring of the National Offender Management Service

Unless overcrowding is addressed and staff continue to carry out offender management work, it is increasingly likely that rehabilitation work needed to reduce the risk of prisoners reoffending will not be provided and that prisoners will not be ready for transfer to open conditions or release.

We were not reassured that the Agency has done enough to address the risks to safety, decency and standards in prisons and in community services arising from staffing cuts implemented to meet financial targets.[22]

My point here is not that I think efficiencies can't and shouldn't be made – I do - and we have certainly seen establishments improve despite the savings they are required to make. Nor am I opposed to many of the government's policy ideas – in particular I welcome the emphasis on rehabilitation. My point is simply this. If you are asking a significant number of inherently risky organisations to do more with less – it is just simply prudent to consider that the level of risk might increase and that needs to be monitored and managed carefully.

Learning from the Mid Staffs Inquiry

Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission (HCC) which published a highly critical report in March 2009. This was followed by two reviews commissioned by the Department of Health. These investigations gave rise to widespread public concern and a loss of confidence in the Trust, its services and management. Consequently, the then Secretary of State for Health, Andy Burnham MP, asked Robert Francis to conduct an Inquiry into what had gone wrong.

The formal text of the inquiry report hides the horror of what actually happened. In his lecture, Robert Francis quoted this account from the relative of a patient in the notorious Ward 11:[23]

"In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for the nurse, "Nurse, nurse", and it just went on and on.

And then very often it would be two people calling at the same time and then you would hear them crying, like shouting "Nurse" louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed.

And then after they would sob, they seemed to then shout again for the nurse and then it would go quiet... "[24]

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[22] Rt Hon Margaret Hodge MP, Chair of the Committee of Public Accounts 05 March 2013

[23] Report of the Mid Staffordshire NHS Foundation Trust public Enquiry Volume 3, Paragraph 23.8

[24] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 3, Paragraph 23.9

I suppose at least older prisoners in a prison with night sanitation have a pot – so that's better isn't it?

Here is another example Francis quotes. The daughter-in-law of a 96 year old patient:

> *We got there about 10 o'clock and I could not believe my eyes. The door was wide open. There were people walking past.*
>
> *Mum was in bed with the cot sides up and she hadn't got a stitch of clothing on. I mean, she would have been horrified.*
>
> *She was completely naked and if I said covered in faeces, she was. It was everywhere.*
>
> *It was in her hair, her eyes, her nails, her hands and on all the cot side, so she had obviously been trying to lift her herself up or move about, because the bed was covered and it was literally everywhere and it was dried. It would have been there a long time, it wasn't new.*

To be fair, I don't think I have ever seen anything like that in a prison, but I have seen elderly, physically disabled and mentally ill prisoners in conditions – where they had been for long periods - which could only be described as degrading.

So what were the warning signs in Mid Staffordshire that were missed that allowed that situation to develop? Francis sets out seven. First, patient stories of the sort I have just described. Too often these were not heard or dismissed in Mid Staffs hospital – and of course one of the significant risks in a prison is that if prisoners talk about victimisation or neglect they can easily be dismissed as not credible. I think one of the things my predecessors got absolutely right at the inspectorate, and I have simply continued, is to put what prisoners tell us at the heart of our inspection process. I remember asking one of our inspectors who had been seconded from the prison service and was returning to her prison to work what she had learnt from her time at the inspectorate. "To listen to prisoners" she said. That's a hard thing for those who work in prisons when time is short and you are rushing from task to task but neglect it at your peril.

The second warning sign was mortality data. By this, Francis was referring to the statistics that suggested patient mortality was much higher than should have been expected, and the trust's inadequate response to it. The number of self-inflicted deaths in prison has thankfully come down from the levels of a few years ago but it still remains much too high. In my 2011/12 Annual Report I reported:

> *The number of self-inflicted deaths in prison rose from 54 (0.64 per 1,000 prisoners) in 2010–11 to 66 (0.76 per 1,000 prisoners) in 2011–12. Three children held in Young Offender Institutions killed themselves.*
>
> *It remains to be seen whether this rise is an anomaly, or whether it heralds the reversal of a downward trend in the number of self-inflicted deaths in prison.*

Incidents of self-harm are, however, also rising in men's prisons – from 14,768 in 2010–11 to 16,146 in 2011–12 (the number fell in women's prisons) – as are the number of recorded assaults, from 13,804 to 14,858.

Taken together, these figures are a matter of real concern.

When we compared survey results for prisons inspected this year with those from their previous inspections, prisoners' perceptions of their safety had significantly worsened in twice as many prisons as those where they had significantly improved.[25]

The figures I quoted in my last annual report cover the period April 2011 to March 2012. We can't do an exact comparison for this year yet, because the NOMS safety data figures are not available for the first quarter of 2013. However, we can compare the figures for the calendar year 2011 and the calendar year 2012. They paint a similar picture to those I reported in our last annual report. The number of self-inflicted deaths rose from 57 in 2011 to 60 in 2012. This represented a slight increase in the number of self-inflicted deaths per 1000 from 0.66 to 0.7.[26] The incidence of self-harm continued to rise in men's prisons from 15,829 incidents in 2011 to 16,567 in 2012. The number of self-harm incidents in women's prisons continued to fall although the rate per 1000 remains significantly higher than that in men's prisons. [27]

The number of assaults of all types fell, I am pleased to say. That may reflect the fall in the number of young people in custody. The number of assaults involving young people aged 15-20 fell sharply – while those involving older men aged 21 to 40 grew.[28]

And as we have seen, our inspection assessments suggest that levels of safety have fallen over the year but the decline has not been as sharp as in some other healthy prison tests. In my view the evidence continues to suggest at least a concern about declining safety levels.

The other broader point that Francis makes about the mortality statistics at Mid Staffs is that there were some valid methodological criticisms that could be made of the way they were used but there was no doubt that the overall message they gave was substantially correct. The reaction of management to data that was giving them unwelcome news was to try and find reasons why it might not be true rather than to act on the basis it might be, until proved otherwise.

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[25] HMI Prisons Annual report 2011/12 Introduction

[26] Ministry of Justice: Safety in Custody Statistics England and Wales Update to December 2012: Deaths

[27] Ministry of Justice: Safety in Custody Statistics England and Wales Update to December 2012: Self-harm

[28] Ministry of Justice: Safety in Custody Statistics England and Wales Update to December 2012: Assault in prison custody 2002 -2012 Table 3.3 assaults by age

The third missed warning sign he identifies were complaints. Complaints at Mid Staffs were often dealt with by the unit to which the complaint referred, defensively, slowly and with very little remedial action taken. The Trust Board was not told the substance of any complaints. Taken together they should have been a loud and clear warning that something was wrong. Nevertheless, Francis cautions against too great a reliance on the complaints system. Some patients were unable to complain on their own behalf and had no friends or family visiting them who could take up a complaint for them. In addition, patients and their families were often scared to make a complaint for fear of repercussions.

So what about prison complaints? Do those of you who work in prisons know the patterns and trends of prisoner complaints in your prison? Are you confident that they are dealt with by staff who are not directly involved? Are complaints answered promptly, courteously and followed through and where necessary is remedial action taken?

Francis quotes one relative of a patient who told him this:

> *Some of them were so stroppy that you felt that if you did complain, that they could be spiteful to my Mum or they could ignore her a bit more[29].*

I tell you, that is exactly what some prisoners' families tell me when they write to me with a concern about how they or a relative in prison is being treated.

The government's consultation paper on changes to the legal aid system makes heavy reliance on the prisoner complaints system. I think they need to be more cautious. In our response to the consultation paper we point out that our inspection evidence suggests that the prisoner complaints system cannot be consistently relied on. In our surveys last year, 13% of prisoners told us it was hard to make a complaint, two thirds of those who did so felt it had not been sorted out fairly and nearly one in five told us they had been prevented from making a complaint[30]. We find repeated examples of the person about whom the complaint is made being the same person who answers it.

Don't underestimate the importance of this. An effective complaints system in which prisoners have confidence was seen as an essential part of the remedy to the Strangeways riots by Lord Woolf's report.[31]

The fourth missed warning sign was staff and whistleblowers who did raise concerns but there was a bullying and dismissive response when they did. Francis also gives reasons why more staff did not raise concerns: Shame. Some staff felt personally ashamed of the poor care they felt they were obliged to give.

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[29] Robert Francis QC Kings Fund Conference 27 February 2013 Lessons from Stafford

[30] Submission to Ministry of Justice: Transforming Legal Aid – delivering a more credible and efficient system. HM Chief Inspector of Prison 4 June 2013

[31] HM Chief Inspector of Prisons Annual Report 1996 - 1997

Next, what Francis describes as 'the sound of pain'. One staff member told him this:

> *The nurses were so under-resourced they were working extra hours, they were desperately moving from place to place to try to give adequate care to patients. If you are in that environment for long enough, what happens is you become immune to the sound of pain. You either become immune to the sound of pain or you walk away. You cannot feel people's pain, you cannot continue to want to do the best you possibly can when the system says no to you, you can't do the best you can.*[32]

I was talking to a group of sessional staff who visit prisons regularly at an event last weekend and they described exactly that. They felt overwhelmed by what they were dealing with and simply had to shut out all the distress they were hearing or leave.

This is a quote from an inspection report about Cookham Wood YOI in 2009.

> *The living units were very noisy, with cell bells constantly ringing and young people shouting to each other and staff when locked in their cells. The noise of cell bells was exacerbated because they rang on both units whenever they were activated. Staff and young people told us that cell bells were used frequently by young people to gain staff attention for routine matters and it seemed to have become an accepted form of communication. Consequently, cell bells were not responded to with any sense of urgency and the risk of failure to respond to a genuine emergency was high. Observation panels and windows on stairwells were regularly broken and rubbish from cells emptied into the corridors.*[33]

Cookham Wood, I should say, has improved beyond all recognition since we did that inspection but that extract from the report captures how staff shut out what they heard and saw in the way Francis describes.

Then there is crude self-interest. Staff don't raise things because they perceive it will be damaging for them in some way or they simply want a quiet life.

The fifth missed opportunity to see the warning signs that Francis says was missed was the governance of the trust. There were some organisational failures which may be specific to a health setting but Francis also describes a set of attitudes which meant that opportunities to see and act on warnings were missed. Those who work in prisons may recognise some of these:

- A mindset of uncritical scepticism by managers about complaints and concerns?
- The comfort of poor practice being common – 'we're not the worst'?
- An over-reliance on insufficiently rigorous external inspection and scrutiny findings?

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[32] Robert Francis QC Kings Fund Conference 27 February 2013 Lessons from Stafford

[33] HMI Prisons: Report on an announced inspection of HMYOI Cookham Wood (2-9 February 2009) by HM Chief Inspector of Prisons

And finally Francis points to two other factors. Reductions in staffing and finance and the reorganisation required to achieve these without properly thinking through their implications for patient care. Of course, Robert Francis does not argue that the NHS or Mid Staffs hospital should be exempt from the financial constraints that all public organisations face. As I understand it, what he argues is that insufficient weight was given to the impact on patient care in considering the various options. Why then were these warning signs missed and opportunities to put things right ignored?

- Users were not heard
- The significance for users of concerns, reorganisations, information was overlooked
- The cumulative effect of concerns was not considered
- Some key decision makers had insufficient support and expertise
- There was an assumption that "someone else was dealing with it"
- Safety relevant information was not shared – how often do we see that in prisons?
- There were barriers to information sharing.

All these factors came together to create a negative culture which he describes like this:[34]

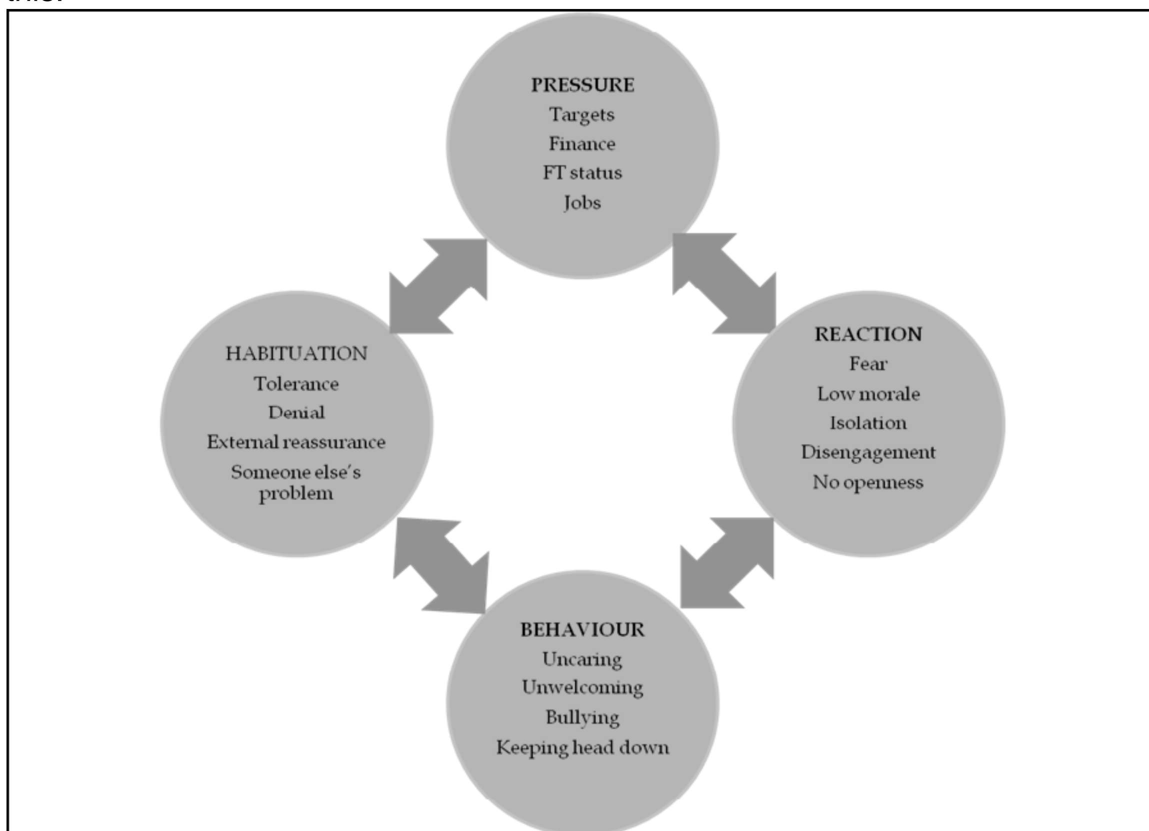

Figure 7 Mid Staffs: a negative culture

[34] Robert Francis QC Kings Fund Conference 27 February 2013 Lessons from Stafford

This is what he described as existing in Mid Staffs hospital – I recognise it as a pretty good description of the common features of a failing prison. The failures were not just internal to Mid Staffs Hospital. The external regulatory and inspection mechanisms also failed. He described regulators and inspectors as concentrating on the system's business, not patients.

- He said regulators had standards which missed the point
- There was too great a focus on finance, corporate governance and targets
- There were regulatory gaps
- Inspectors balanced "bad" news with "good" regardless of the objective weight different findings should have. And the recipients of inspection findings naturally heard the good news better than the bad.
- Inspectors *assumed compliance* rather than *fearing non compliance*
- And too often they accepted positive information uncritically whilst rejecting the negative.

Conclusion

Let me say again why all this is relevant to the prison service. Contraction in an age of expansion means contacting resources whilst meeting expanding requirements, in other words doing more for less.

In an organisation that has managing risk as a core function, it must increase the level of risk that has to be managed. I am not predicting murder and mayhem, but what I am saying is that what we are finding on our inspections now might be evidence that the level of risk may indeed be increasing. If that is the case, it is my contention that Robert Francis' Inquiry into Mid Staffs hospital has lessons from which the prison service, if it was prudent, could learn. I say this not to point the finger at things that are going wrong, but to try and prevent that happening, as is my duty to do.

So what are the remedies? Again what Robert Francis talked about in relation to Mid Staffs has relevance for the prison service. He stressed the need for strong common values and fundamental standards – standards that reflect what the public see as essential. For me that reinforces the value of our human rights-based, outcome-focussed Expectations. And since coming into this role, I have been struck by the very consistent support there is for that approach from prison managers and staff themselves. I think they are viewed more uneasily in some other quarters - but we will not change that approach. When those standards are breached in hospital, Francis urges that services should be closed, where appropriate, individuals held to account and individual incidents investigated and remedial action taken. My experience is that if I have raised serious concerns with NOMS management following an inspection, action is taken which I welcome. You would be a better judge than I of whether that represents the general picture.

Francis urges the need for openness, candour and transparency. In prison terms, I think that needs constant attention as the nature of the business may create a culture that militates against it.

Finally he talks about a system of regular and risk-based inspection with which providers have a duty to co-operate, that has user experience at its heart and one that does not rely on self-assessment but requires proof of compliance with fundamental standards.

If you look at these remedies that Robert Francis proposes for the health service, the prison service could say with some justification that many, although not all of them, are in place and I hope we contribute to that. So while I believe that the prison service is carrying a higher level of risk, and some of the features Robert Francis found in Mid Staffs can be found in failing prisons and so need vigilance to prevent, I think it is better placed to identify and remedy them. However, the systems for doing so are now stretched and my advice to Ministers is to be very, very careful before they stretch them further or expect them to carry a heavier load.

When he submitted his report, Robert Francis wrote a covering letter to the Secretary of State for Health which was published alongside the report. In the final paragraph of the letter he says this:

> *"If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented."*[35]

Not a bad message, I would say, for the politicians, civil servants, NOMS, governors, prisoner officers, staff – and inspectors trying to help the prison service deal with contraction in an age of expansion.

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[35] Robert Francis QC; Press release: Final Report Of The Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust