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# **HIV/AIDS AND THE PRISON SERVICE OF ENGLAND & WALES, 1980s-1990s**

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The transcript of a witness seminar held by the Centre for History in Public Health, at the London School of Hygiene and Tropical Medicine, 18 May 2017

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## **ABBREVIATIONS**

<b>ACMD</b>	Advisory Council on the Misuse of Drugs
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>BMA</b>	British Medical Association
<b>CMO</b>	Chief Medical Officer
<b>GUM</b>	Genito-Urinary Medicine
<b>HA</b>	Home Affairs
<b>HEA</b>	Health Education Authority
<b>HIV</b>	Human Immunodeficiency Virus
<b>HMP</b>	Her Majesty's Prison
<b>HMPS</b>	Her Majesty's Prison Service of England & Wales
<b>HTLV-III</b>	Human T-Lymphotropic Virus Type III
<b>IRA</b>	Irish Republican Army
<b>MDT</b>	Mandatory drug testing
<b>NACRO</b>	National Association for the Care and Resettlement of Offenders
<b>NAT</b>	National AIDS Trust
<b>NHS</b>	National Health Service
<b>PHLS</b>	Public Health Laboratory Service
<b>POA</b>	Prison Officers Association
<b>PrEP</b>	Pre-exposure prophylaxis
<b>PRS</b>	Prisoner Resource Service
<b>RAPt</b>	Rehabilitation for Addicted Prisoners Trust
<b>TB</b>	Tuberculosis
<b>VIR</b>	Viral Infectivity Regulations
<b>WHO</b>	World Health Organisation

## INTRODUCTION

AIDS first appeared in Europe in the early 1980s, and prisons were soon identified as sites that would face particular challenges. Injecting drug use was one of the primary modes of HIV transmission, and the large numbers of drug users passing through prisons meant that the prevalence of HIV was feared to be high.<sup>1</sup> Added to this were suspicions about the frequency of risky sexual activity and injecting drug use within prisons. Prisoners were not only thought to be at a higher risk of already having HIV or AIDS, but prisons themselves were seen as an ideal environment for the spread of infection amongst inmates, potentially also from inmates to staff, and ultimately from released prisoners to the wider population. For Her Majesty's Prison Service of England & Wales [HMPS], the situation first became pressing in early 1985. In Chelmsford, the death from an AIDS-related illness of the prison chaplain Gregory Richards saw the Prison Officers' Association banning all movement of prisoners in and out of the prison, accompanied by lurid headlines and widely publicised concerns over contagion via the communion cup. Urgent decisions had to be made about how to minimise disruptions of this kind, how to reduce the risks of HIV transmission, and how to look after prisoners with HIV or AIDS.

This Witness Seminar, held at the London School of Hygiene and Tropical Medicine in May 2017, brings together some of those involved in influencing and implementing prison policy decisions surrounding HIV and AIDS in the 1980s and 1990s. The Witness Seminar is a means of creating material for recent history. The technique is essentially group oral history, though the participation of eminent individuals sets it apart from mainstream oral history practice. The strengths and limitations of the method reflect those of oral history more broadly: participants may have good or inaccurate recall, may be candid or rehearse the received wisdom, and inevitably some witnesses are absent. The group setting carries additional pitfalls, in that some aspects of the story may not be considered suitable for public discussion or participants may be unwilling to interact. Nonetheless, when carefully triangulated with other sources it has significant virtues. The direct testimony of influential actors can generate

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<sup>1</sup> Gary P. Wormser, 'Acquired Immunodeficiency Syndrome in Male Prisoners: New Insights into an Emerging Syndrome', *Annals of Internal Medicine*, 98.3 (1983), 297.

valuable new insights, and can illuminate issues such as individual motivation, interpersonal dynamics and intellectual and cultural influences. Group interaction cannot aspire to generate a perfect collective memory, but it has other attributes, prompting recollection and exposing areas of consensus or dissent.<sup>2</sup> With this in mind, a lack of representativeness and collusive construction of historical narrative may also be viewed as strengths. A transcript reveals how participants make their vision of history, replete with their ideological and theoretical assumptions; the point is not simply to look for the facts, important as these may be, but also to think of witnesses as ‘bearers of culture’ who can reveal much about these assumptions.

As this transcript shows, despite some shared impressions of a prison service that was often slow-moving and reluctant to change, many of our witnesses were at pains to emphasise the fears surrounding HIV and AIDS, the lack of firm information, and the lack of evidence regarding best practice, not only in prisons but in the wider community as well. Over three decades have now passed since those early days. With HIV now a manageable condition in the West, thanks to treatments that enable most people with the virus to live a long and healthy life, many of those who remember HIV and AIDS in the 1980s are keen to convey just how different the situation was then. As several witnesses mention, prison service staff and prisoners were not immune to the views and anxieties circulating in wider society. Problems and paranoia may then have been exacerbated by the closed environment of the prison. The Prison Officers’ Association [POA] had an influential voice in the 1980s, and called for staff to be made aware of the identities of prisoners with HIV or AIDS, in breach of national policies that followed principles of medical confidentiality.<sup>3</sup> As the recollections here of Sir Richard Tilt and John Dring indicate, POA branches were not always problematic at the local level, although it may be that their anxieties were lessened when staff had knowledge as to who in the prison had HIV or AIDS. At a time of considerable fear, this provided some sense – albeit a false one – of security.

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<sup>2</sup> Virginia Berridge, ‘Hidden from History? Oral History and the History of Health Policy’, *Oral History*, 2010, 91–100.

<sup>3</sup> The POA passed a resolution to this effect in 1987. See Prison Reform Trust, *HIV, AIDS and Prisons* (London: Prison Reform Trust, 1988), p. 11.

The question of segregation was much debated in these early years, including within the AIDS & Prisons Forum, convened by the National AIDS Trust [NAT] and the National Association for the Care and Resettlement of Offenders [NACRO]. As Dame Ruth Runciman explains, the Prison Service initially allowed individual prisons to implement Viral Infectivity Regulations to prisoners with HIV or AIDS. This could involve housing prisoners separately from the general population and restricting their work or sports activities, at the discretion of the prison doctor. It was a means of segregation to prevent the spread of HIV, although at the time its merits for people with HIV and AIDS were also considered. Some prisons, such as Wandsworth in London, created separate wings for prisoners with HIV or AIDS and this persisted into the 1990s, while others did not introduce any special measures at all. In the uncertain 1980s, HMPS prepared for cases of AIDS amongst prisoners by designating sections of Risley, Brixton, and Gartree prisons as AIDS hospital units.<sup>4</sup> As we hear in the witness seminar, in the end, these were barely used: more information and improved treatments were emerging, and the numbers and needs of prisoners were less than expected. Prisoners requiring specialist treatment were transferred to external hospitals. On the clinical side, the most significant problem was remembered as the interruptions to drug regimens that could occur once people with HIV or AIDS entered the criminal justice system.

In general terms, though, there were concerns throughout the 1990s about the quality of healthcare provided to prisoners, and the transfer of prison medicine to the NHS in 2006 was significant. Dr Mary Piper remembers vividly just how little funding the prison medical service had when she first joined, and describes her sense of a health service that had been abandoned. Prison doctors themselves receive a mixed report card, reflecting wide variations across a large prison estate. Such variations were evident in the approach to drug addiction, where doctors were very much left to their own devices. Drug addiction services in the UK had changed significantly in response to HIV and AIDS, to favour harm minimisation efforts including needle exchanges, the provision of information about sterilising needles, and the long-term prescribing of methadone as a heroin substitute. As Dr Hilary Pickles confirms, the

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<sup>4</sup> Only the Gartree unit is discussed in the Witness Seminar. For more on these units, see House of Commons Social Services Committee, *Third Report from the Social Services Committee: Prison Medical Service* (London: HMSO, 1986); Prison Reform Trust, *HIV, AIDS and Prisons: Update*, (London: Prison Reform Trust, January 1991).

drug treatment community was not initially enthusiastic about this, but even after most had been won over, the prison service maintained its resistance. Our witnesses agree that the prison service was in denial until the mid-1990s that drug addiction amongst prisoners and drug use in prison was a problem. Some felt that there was relatively little injecting taking place within prisons, but Mike Trace outlined a shift in prison and crime cultures over the 1980s that saw drugs beginning to feature much more prominently within the environment of the prison. Paolo Pertica describes the particular needs of prisoners from overseas, and this in part prompted the establishment of European networks to share best practice in relation to HIV and prisons. Ultimately, official recognition of the extent of addiction problems and drugs in prisons brought an element of unwelcome political attention, but eventually also new strategies and all-important funding.

This new attention re-energised previous debates over allowing disinfecting tablets or bleach within prisons for inmates to clean injecting equipment to prevent infection, an issue that remained contentious well into the 2000s. Disinfecting tablets were first introduced very briefly in 1995, and efforts to reintroduce them in the decades since have met with many obstacles. Drug services in other forms also failed to receive the support of prison staff at times, including early services such as the Parole Release Scheme and later initiatives such as dedicated and medically supervised detoxification units. In her recollections below, Jan Palmer describes a key turning point for her in gaining the trust of staff, before which she was viewed with some suspicion as both an ‘outsider’, on secondment from the NHS, and a substance misuse specialist delivering services of uncertain value to addicted women.

Although the issues of addiction and drug use feature particularly prominently in discussions of prison responses to HIV and AIDS, the matter of sex amongst prisoners was not entirely ignored. As charities, health authorities, and gay community groups worked to spread information about safer sex in the 1980s and 1990s, there were calls at national and international levels for prisons to play their part and to provide condoms to inmates.<sup>5</sup> This

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<sup>5</sup> For example, Council of Europe, Parliamentary Assembly, ‘Recommendation 1080 on a Coordinated European Policy to Prevent the Spread of AIDS in Prisons’, 1988, available from <http://hrlibrary.umn.edu/instree/recommendation1080.html>; Advisory Council on the Misuse of Drugs, *AIDS and Drug Misuse: Part One* (London: Advisory Council on the Misuse of Drugs, 1988).

was vetoed in the 1980s, and we hear about several of the concerns that was raised with the Department of Health AIDS Unit. It was much debated whether prisons were private places for the purposes of the Sexual Offences Act 1967, and whether therefore the provision of condoms could be viewed as encouragement to commit a sexual crime. It was also feared that condoms could be used in constructing weapons. The provision of condoms was vetoed again in the 1990s, this time by the Home Secretary Michael Howard, contrary to the recommendations of the Prison Board. This time, the director of the prison medical service Dr Rosemary Wool found something of a workaround, and doctors in some prisons began to prescribe condoms and dental dams. Nevertheless, witnesses including John Podmore maintain that the prison service consistently failed to address sexual violence within prisons, and its policy on condoms has also been the subject of criticism from the mid-1990s to the present day.<sup>6</sup>

The emergence of HIV and AIDS highlighted many of the existing tensions and problems surrounding healthcare for prisoners. It exposed what Andrea Kelmanson describes as something ‘doggedly resistant’ about the service, in its apparent reluctance to acknowledge and tackle difficult issues. Fears of bad headlines, pressures of a political nature, and a focus upon the day-to-day demands of running a prison all played a role, and there could be a significant gulf between policy and practice. Ultimately, and despite some heightened fears and tensions in the 1980s, HIV and AIDS were not at any time a top priority for the prison service, although many individuals, particularly Len Curran and Rosemary Wool, worked extremely hard behind the scenes to bring about whatever changes they could. Our witnesses also observed that, for whatever reasons, there did not seem to have been an HIV or AIDS epidemic within prisons, despite the many problems that were identified. What also emerged was a sense of some of the ongoing difficulties facing the prison service, in terms of lost gains in healthcare services, mounting overcrowding, and a failure to learn the lessons of the past.

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<sup>6</sup> Critiques have come from the Advisory Council on the Misuse of Drugs, *Drug Misusers and the Criminal Justice System, Part Three: Drug Misusers and the Prison System: An Integrated Approach* (London: HMSO, 1996); the British Medical Association’s Foundation for AIDS, in *Prescribing of Condoms in Prison: Survey Report* (London: BMA Foundation for AIDS, 1997); and the Howard League, in Ailsa Stevens, *Sex in Prison* (Howard League for Penal Reform, 2015).

## **PARTICIPANTS**

### **Panel**

**Dame Ruth Runciman**, former Chair of the Advisory Council on the Misuse of Drugs AIDS & Drugs Misuse Working Group.

**Sir Richard Tilt**, former Director General of HMPS.

**Mr Mike Trace**, Director of the Criminal Justice Service at Cranstoun Drug Services.

**Mr John Dring**, former HMPS Governor and Area Manager.

**Ms Andrea Kelmanson**, former National AIDS Trust Deputy Director.

**Ms Jan Palmer**, former Clinical Substance Misuse Lead for Offender Health.

**Mr Paolo Pertica**, former Remand Drug Worker then Manager at Cranstoun Drug Services.

**Dr Hilary Pickles**, former Principal Medical Officer in the Department of Health AIDS Unit.

**Dr Mary Piper**, former Senior Public Health Adviser for Offender Health.

**Mr John Podmore** former HMPS Governor.

**Also in attendance:** Dr Hayley Brown, Dr Holly Dunbar, Professor Wayne Hall, Dr Hannah Kershaw.

**Apologies include:** Mr Colin Allen, Mr Derek Bodell, Professor Sir Kenneth Calman, Dr Silvia Casale, Ms Frances Crook, Dr Dorothy Black, Dr Karen Duke, Dr Paul Hayes, Mr Roger Howard, Mr David Marteau, Sir Martin Narey, Lord David Ramsbotham, Mr Stephen Shaw, Ms Stephanie Sexton, Professor Joe Sim, Professor Sir John Strang, Ms Kate Thomson, Professor Kaye Wellings, Dr Rosemary Wool, Dr Nat Wright.



*(L-R) Paolo Pertica, John Podmore, Mike Trace, Richard Tilt, Ruth Runciman*

## TRANSCRIPT

Professor Virginia Berridge: My name is Virginia Berridge, and I'll be chairing the seminar this afternoon. Both myself and Janet Weston are working on a project on HIV and prisons from the 1980s to 2000. This is part of a bigger project on prisons and healthcare over a much longer period, 1850 to 2000, so we are the very contemporary history project within that.<sup>7</sup> It's directed by Professor Hilary Marland at the University of Warwick and Dr Catherine Cox at University College Dublin, so it's a comparative British/Irish study. Our study, too, is a comparative study of HIV in British and Irish prisons, but today we are going to focus very much more on the English case.

The idea of a witness seminar is probably familiar to some of you, but maybe not to everyone, so I thought I would just briefly talk about what it is. It's a kind of historical focus group, where people who have been involved in events in the past get together to discuss their memories of events. So unlike a normal academic conference where people have researched something and are presenting their research and are open to comment and criticism, it's very much a more open-ended, more personal process, where people talk about their own experiences and their own memories of the past. Everything is important to us in that respect.

There have been many other witness seminars organised through the Centre for History in Public Health here at the London School of Hygiene & Tropical Medicine, and if any of you want to look at some of those, they are on our website. They range from the smog of the 1950s, to the reorganisation of health service funding in the 1970s: a very eclectic range of witness seminars.<sup>8</sup>

Our panel are going to talk for about five or ten minutes each about their memories of the period and then we'll open it up to the group. I'd like to introduce our panel now and hand over to them. Our panellists are Dame Ruth Runciman, who was on the Advisory Council on the Misuse of Drugs [ACMD] from the mid-1970s to the mid-1990s, and was also Chair of the

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<sup>7</sup> Information about the wider project can be found at <<https://histprisonhealth.com>>.

<sup>8</sup> Transcripts of the witness seminars organised by the Centre for History in Public Health are available from <<http://history.lshtm.ac.uk/witness-seminars/>>.

National AIDS Trust and a founding trustee and Deputy Chair of the Prison Reform Trust. Next to her is Mike Trace, who was Director of the Cranstoun Parole Release Scheme, Deputy Anti-Drugs Coordinator in the late 1990s and early 2000s, and is currently Chief Executive of RAPt, the Rehabilitation for Addicted Prisoners Trust. Then our third panellist is Sir Richard Tilt, Assistant Governor and Governor in Her Majesty's Prison Service from the mid-1960s to the 1990s and Director General of the Prison Service from the mid-1990s to the end of the 1990s. Ruth, would you like to go first?

Dame Ruth Runciman: My contribution is based on the reports of the Advisory Council on the Misuse of Drugs, the working groups that I had the privilege of chairing. There were three reports on AIDS and drug misuse between 1988 and 1993, and then another report on drug misusers in the prison system, in which Mike Trace played a very valuable part.<sup>9</sup>

The overarching conclusion of all this work was that the spread of HIV is a greater danger to the individual and public health than drug misuse. Accordingly, services which aimed to minimise HIV risk behaviour, by all available means, should take precedence in development plans. It was of course the progenitor of harm reduction which today would be taken rather for granted, but it caused a very considerable stir 30 years ago. After the reports, the Government, to its credit, accepted our recommendations in principle and in practice took forward a series of harm reduction initiatives starting with needle exchange. Harm reduction in this country, I think it's not too proud to say, did become a model in other countries and was responsible over the next 15 years for contributing to a very significant curb on the spread of HIV through drug use.

Each of the reports stressed the importance of the prison system in relation to the spread of HIV, in particular because of the large numbers of drug misusers who were spending some time in prison, many of whom had had no previous contact with services and many of whom, both men and women, were injectors. Many of the women prisoners had also had some

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<sup>9</sup> Advisory Council on the Misuse of Drugs, *AIDS and Drug Misuse: Part One* (London: HMSO, 1988); Advisory Council on the Misuse of Drugs, *AIDS and Drug Misuse: Part Two* (London: HMSO, 1989); Advisory Council on the Misuse of Drugs/Department of Health, *AIDS and Drugs Misuse: Update* (London: HMSO, 1993); and Advisory Council on the Misuse of Drugs, *Drug Misusers and the Criminal Justice System, Part Three: Drug Misusers and the Prison System: An Integrated Approach* (London: HMSO, 1996).

involvement in prostitution. By 1989, drug misusers formed the fastest growing group of people with HIV and AIDS in this country. There was also evidence to suggest, particularly in overcrowded prisons where there was a lot of cell sharing going on, that homosexual acts were occurring between male prisoners to a significant extent.

The reports all had similar recommendations in respect of prisons, with different emphases in accordance with what developments had taken place in between. We said it was necessary to substantially increase the number of drug users who were identified as soon as possible after admission, in order to work with them to adopt safer practices and to consider maintenance prescribing, particularly for those remanded, or on short sentences. But there was a continuing lower rate of identification, which did emphasise the need for incentives, including prescribing. There was of course a fairly strong argument for reducing the number of people – drug users – who were sent to prison on short sentences in the first place and particularly on remand, which was found to be a particularly unfortunate thing in respect of activities that were adding to potential HIV infection.

We said the testing for HIV should only be undertaken confidentially with consent, preceded and followed by counselling, which was the prison service's policy at the time. That principle was undermined by the introduction of VIR, viral infectivity restrictions in the mid-80s, whereby inmates with HIV or with hepatitis were to be isolated in single cells, or to share cells with another prisoner who was similarly affected and to be excluded from a range of activities in prison, including PE and Games.<sup>10</sup> The implementation of this policy was inconsistent and different medical officers placed different restrictions on prisoners. By 1988, the prison department was advocating that inmates with HIV should wherever possible be on ordinary location and be involved in ordinary activities in the prison. In 1992, we found that 40 out of 120 prisons were still practicing VIR.

When we came back to look at the issue in 1996, we found that VIR had been abandoned, that patient confidentiality was much better protected, and that there had been major efforts to advance drug education for both staff and prisoners in harm reduction and the risk of HIV

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<sup>10</sup> The policy on VIR was outlined in *Report of the Work of the Prison Department for 1985/86* (London: HMSO, 1986), p. 46.

and hepatitis infection and how to avoid them. Nevertheless, we did receive evidence that drug education and harm reduction information was still reaching only a minority of the prison population and there was a lot of work still to do, including making sure that this information addressed the needs of women prisoners and prisoners from black and minority ethnic communities.

Despite the temptation to advocate needle exchange, which was taking place in Europe in a few prisons, in all the reports we recognised that there were legal problems that made offering injecting equipment in prison quite unrealistic. Inevitably, needles and syringes were getting into prison and were getting shared. We therefore recommended that decontaminants, particularly sterilising tablets, should be made available to prisoners along with good information about the elementations and the risks involved in sharing injection equipment. These were introduced in 1995, but were withdrawn on advice from the Department of Health, much to our surprise, and we never quite understood why. There was then a pilot project in 1998 in eleven prisons.<sup>11</sup> When the Prison Reform Trust and the National AIDS Trust conducted a survey of prisons in 2004, only 8 of the 61 prisons who answered this question were making sterilising tablets available.

In each report we also urged there should be easy and confidential access to condoms. In 1996, we found that prisoners were getting access to condoms on release on home leave and on discharge, but in prisons they were only entitled to condoms on prescription. Of course, the take up was not surprisingly very low. In 1996 we concluded that the prison service had made substantial progress in developing its strategy and response to HIV, but also that there was still a very considerable gap between policy and practice.

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<sup>11</sup> The evaluation of the 1998 pilot project confirmed that disinfecting agents had been introduced in 1995, but a few weeks after the tablets were delivered 'concerns were raised. Anxieties relating to the possible release of noxious gases in the event of a fire were expressed by both Governors and staff associations in England & Wales. Information from the tablet manufacturer regarding the amount and types of gas that would be released on combustion of the tablets was conflicting or not available, and the tablets were withdrawn on the advice of the Health & Safety Unit at Prison Service Headquarters'. LSHTM Health Promotion Research Unit, *Disinfecting Tablets Pilot Project 1998: An Evaluation* (London: LSHTM, 1998), p. 1. This report was not published, but a copy is held in the HIV/AIDS collection at the LSHTM Archives [uncatalogued]. It also confirms that disinfecting tablets were made available in Scottish prisons following an outbreak of HIV and hepatitis B at HMP Glenochil in 1993.

It's important to remember that the health service in prison was the responsibility of the prison service at that time and many prison medical officers simply lacked, very understandably, expertise in HIV disease and prevention, much of which was provided as Mike Trace will well know, by specialist drug agencies. A hundred of them in 1996, working without formal contracts and without assured funding. Also by GUM clinics, Genito-Urinary Medicine clinics where there were clinics near to prisons, which obviously was not all prisons. It was only in 2006 when prison healthcare commissioning was transferred to NHS there was the first real opportunity to achieve equivalence in healthcare for HIV and hepatitis and also to achieve a real progress in harm reduction initiatives consistently across the prisons.

Berridge: Thank you very much. Mike?

Mr Mike Trace: Thank you very much to our hosts and thanks very much to Ruth for reminding me of lots of things I'd forgotten. I'll start with the get-out clauses. I am much less well prepared than Ruth was, so I've been scribbling some notes as I've been listening. Also, memory fails: this was a long time ago and so everything I say in the next five or ten minutes should be taken with a pinch of salt. I may be remembering it wrong. I'm not very good at recordkeeping!

What I thought I could usefully do is run through those years and what I was doing at the time, and what my impressions were. We intersected on the work we did, committee work together and some campaigning, but I was through most of that time a practitioner working in the prisons. And I've noted down here three interesting dynamics or dilemmas that were going around at that time, the late 80s and early 90s, just to start our thinking about how those were handled.

But just quickly on the timing, when I started in the profession, 1984/85, was around the time that something was happening around infections and what is now known to be the AIDS epidemic. Anybody working in the welfare sector or the criminal justice sector then was aware that something was happening, but as many of you remember it was some years before we knew *what* was happening, giving it a shape and a name in public health terms.

I worked in a probation hostel at the time in North London, which was my first job in the sector. What predated this is that before the early 1980s, the reservoir of people using heroin had not extended to what we'd call the prisoner fraternity. Around the early 80s, we did a lot of work in homeless projects and with people who were in trouble with the law, and saw heroin arrive in those years. Most of my clients in the probation hostel were people who had served reasonably lengthy prison sentences. I would say, stereotypically, they were the north London criminals who used to do Post Offices in the 1960s and 1970s, and that was how they earned their money. They were just discovering that you could make a lot more money drug dealing, heroin dealing, with a lot less risk and a lot shorter sentences at the back end if you were caught. Through those early 1980s, I was very conscious as a raw young social worker, if you could call it that, that this pattern of behaviour was changing significantly as we were watching. A high proportion of the guys in this hostel, which was a release hostel for people as they came out of prison, were reporting that there was a heroin market inside, that there was a culture developing around it and that was part of their normal life. They were partly dealers, partly users, some were addicted and some were dabbling, you know, but something was changing quite significantly around that time.

In 1987 I joined Cranstoun, as was in the introduction, on a project called the Parole Release Scheme.<sup>12</sup> You'll hear from Paolo in a moment, who joined me there a few years later. I came in as the manager of the Parole Release Scheme in 1987, and the Parole Release Scheme had two elements: there was a hostel just off Clapham Common, in the Clapham Junction area, and that was specifically a hostel for released prisoners, and there was a prison visiting service for people in prison who had problems and who might need the hostel. It sounds grand, but the prison visiting service was basically two of the hostel workers who were allowed to go and visit prisons and ask people if they wanted to come to the hostel. So it was without any protocol or anything like that.

I spent most of the late 1980s with my colleagues there visiting prisons, primarily Brixton, but we went to a lot of other prisons as well, walking on to the wings and saying 'Anyone got a drug problem? Do you want a hostel place when you come out?'. Within 2.8 seconds it was

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<sup>12</sup> Cranstoun, established in 1969, is a charity providing services to people affected by alcohol and drug addiction.

clear that there were a lot of people who had a drug problem in the prisons, because you were offering something and they were coming to you and saying 'Yeah, obviously, I'm on parole and I want the hostel place'. But it was genuine; there were a lot of people for whom that was a very genuine issue they were facing on the wings, and they were still using on the wings. I mention that because it might be easy to forget that well into the 1990s the official position of the prison service and of most prison governors was that there wasn't a drug use problem in their prison. For many years, it was kind of a running joke. We worked for many years where you'd go in and talk to people about their drug use that morning or the day before, and then you'd read the official papers that said 'there are no drugs in prisons'. That was the line at the time.

In the late 80s – Ruth has mentioned this and I won't repeat the details – I had the pleasure of contributing to some ACMD work and some other committee work around AIDS in prisons, HIV in prisons, and criminal justice issues around drugs generally. We were just saying on the way in that those were seminal reports, and credit to Ruth's leadership at the time and to others on the ACMD, for trying to get an understanding of what we were dealing with. There was not a lot of data around at the time, and to try to say what is the best medium and long term strategy was— those were febrile times, the late 80s and around 1990. By and large, and I don't want to sound complacent at all, but really good decisions were made. Good advice was given by committees and decent decisions were made in parts of Government. I'll come onto the less decent bits in a minute, but I think you can look back on those years as actually quite a rewarding time. Rewarding is the wrong word, but years when a lot of things were got right.

I carried on working in the prisons through the first half of the 1990s, and through those years, that was when the prison institutions and the ministers responsible for them started to acknowledge the problem. It's a memory of mine, and somebody else may have a different memory, but in the early 90s when we started to make progress with having official acknowledgement of the extent of the challenge on drug use by prisoners and drug use in prison, the emerging interest from political leadership definitely wasn't all that welcome. It was Michael Howard, and the reason why he was interested in it was that he wanted to clamp

down and to say 'I'll stop this'.<sup>13</sup> The main reaction at that time, and I can't remember exactly which year but I presume 92/93 or somewhere around there, was the introduction of mandatory drug testing [MDT], and sanctions on the back of mandatory drug testing, with the objective of creating a drug free prison where any use would not be tolerated. Well, you all know how well that went!

Around that time we were in two minds, because on the one hand there was recognition, budgets were starting to be allocated, the prison health service was starting to hold meetings and say what are we going to do about this. So all very positive stuff. But it was in the context of this ministerial statement that we'll catch them and then punish them more, even though they're already in prison. We're still living with MDT now, by the way. We thought that would be a flash in the pan and not stay all that long, but there is a version of MDT still running in the prisons now.

I went to Government in 1997, and by that time a lot of this work, this opinion and this professional debate had been done. There was pretty much an acknowledgment that there's a lot of people with drug problems in prison, and if you can intervene, and you can manage the environment and provide good health and care inside the prison, you could make progress. It wasn't difficult by the late 90s to say that we need a budget for this, and we need a strategy. I think there was the first prison drug strategy, which Richard will remember better than me. In the early 90s, a decent drug strategy started emerging through to the mid-90s, and it wasn't a politically or financially difficult thing for Government in 97/98 to say 'We know what we should be doing, let's align budgets, let's give priority to it'.

That's my recollection of the arc of how the issue was discussed. As I say, the two overriding things I remember about it, are that genuine dilemma in the mid-1980s (and Ruth alluded to this). It's easy to castigate in terms of history, but it was a genuine battle. There were prison

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<sup>13</sup> Michael Howard was Home Secretary from 1993 to 1997, and famously stated at the 1993 Conservative Party conference that 'prison works'. This has often been seen as a turning point in criminal justice policy: see Joe Sim, *Punishment and Prisons: Power and the Carceral State* (London; Los Angeles: Sage, 2009), pp. 62–64; Karen Duke, *Drugs, Prisons and Policy-Making* (London: Palgrave Macmillan, 2003), p. 23; Richard Sparks, 'Penal "Austerity": The Doctrine of Less Eligibility Reborn?', in *Prisons 2000: An International Perspective on the Current State and Future of Imprisonment*, ed. by Roger Matthews and Peter Francis (London; New York: St. Martin's Press, 1996), pp. 74–93 (pp. 75–76).

managers thinking that the best thing to do here is find out who's got it and isolate them. In a lot of ways, for good human reasons, because people didn't understand what they were dealing with and the extent of what they were dealing with. There was a battle between that and the public health instincts of a lot of us and others, to say 'No, first of all you can't tell who's got it and who hasn't, and second of all there is no way you can isolate this and be complacent', and all that sort of thing. I can remember that battle going on quite fervently in the mid-80s in committees that we had in the National AIDS Trust.

The other obvious battle and particularly the political battle, was the fear of this getting out of control, versus the fear of bad headlines. That was very real for very many years: anything that showed that an illegal activity was happening in the prisons and that the authorities would work with that illegal activity, by providing condoms or needles or any other mechanism. There was a big debate about disinfectant tablets, and that was in the context of ministerial and political and Government fears that this is only going to mean bad headlines for us, even if it makes sense professionally. That was the context in which all of these professional debates were going on.

Something I've always thought since those days and I still haven't worked out – it would be lovely if other people have insights into this over time – is that the strategy improved quite quickly. I think there was a lot of good committee work, and it was not as quick as we would have liked at the time, but it was picked up by authorities and decent strategies followed. But obviously there were massive gaps in those strategies, you know. Anybody who's studied harm reduction activities over the years talks about comprehensive coverage, comprehensive access to clean needles and all of the normal activities we would expect out in the community. And large chunks of that just never happened in UK prisons. There are massive gaps in what you would say is the normal weaponry of reducing drug-related HIV, but it seems that we haven't had any prison-based epidemics yet, so that to me is fascinating.

One of the caveats on that is that I think a political decision was made right back in the 80s: don't survey it. We've never really publicly counted risk behaviour infections amongst prisoners. I can remember us debating this back in 1988, saying that one thing is to know your information, know your epidemic, and there was never a tracking mechanism, or survey

mechanism implemented in the prison system. I thought that was foolhardy at the time. But I've got to say, I've worked in the prisons most of the years since, and we haven't had it there. I don't know why or how or what really is going on, because we haven't really surveyed it, but it's an interesting question to consider. Thank you.

Sir Richard Tilt: A very, very short piece from me. I'd preface it by saying that quite a lot of the things I'll talk about happened more than 30 years ago, so I'm not absolutely sure of my memory at that time. I was ultimately the Director General in the second half of the 1990s, the period you've just been hearing a bit about, and in the context of this piece of research, I was also Governor of Gartree prison in the early-mid-1980s, which is relevant. I won't go into the detail of it now, but it is relevant because from my memory, Gartree was the first prison to be equipped with a special unit for dealing with people with AIDS, and that started in 83 or 84 or something like that. I'm happy to take questions on that because it was an interesting period in Gartree's history.

I was Director General at the time in the late 1990s when we were considering the quality of healthcare in prisons generally. I mean much more widely than the issues that are part of this research, and we started to talk about a possible transfer to the NHS. I guess it was around 1996, 97, 98. I certainly was involved in conducting negotiations with Alan Langlands, who was the Chief Executive of the NHS at that time. We did reach an agreement about transferring responsibility for healthcare services to the NHS, and that was subsequently endorsed by the New Labour Government, I guess around about 1999 and the transfer took place just after I retired I think, probably in 2001 or thereabouts, I'm guessing slightly. We all considered that that was the right way forward.

My memory of the time and the discussions was that there was considerable concern, particularly in senior parts of the service, that the standard of healthcare being provided by the prison service was often below that of the NHS. Particularly issues around, well, not the quality so much, but the skills and training that the staff, known as hospital officers, received by comparison with nursing staff. A first way into all of this was the start of recruiting properly qualified nurses to work in the prison healthcare system, and to start gradually to try and run down the number of hospital officers.

Again this is just reflecting, but I think it's part of what I would call a theme of modernisation. I think there was a general view amongst senior people in the service that you should be doing everything possible to underscore the notion that prisoners were citizens and they should therefore, insofar as was possible, enjoy a similar level of service to people in the outside community. Healthcare was one obvious example of that, but there were others in which that kind of theme was around. It has nothing to do with this, but a particular one was the provision of televisions in cells, where again the argument was very much that this is part of normal life, and we want to keep people in touch with what's going on. I think that applies to the NHS issue as well.

I apologise for being late, but I just came in on the back of the comments about condoms and needle exchanges and sterilisation. I recall that we had a most interesting, but quite difficult Prison Board discussion on this issue and I think it must have been about 1996. It was one of the longest board discussions I can remember on any issue. It went on for a long time. It was a very good discussion actually, with arguments both ways. You can put the arguments in terms of that kind of dichotomy between public health and media attention. We went through all of that. The board in the end, and I think there was only one dissenter, concluded that we should move to provide condoms and needle exchange. As I say, my memory is that it was about 1996 or thereabouts. I had the job the following day of conveying that decision to the Home Secretary<sup>14</sup> and that was the end of it actually, for the reasons that you gave. I mean, he was not in the least bit persuaded or interested. The strong arguments in the Prison Board were public health ones, frankly, and I'm curious that it hasn't turned out to be the major public health issue that we thought it would be. There were financial concerns around the transfer of prison healthcare to the NHS, but that was largely settled in the negotiations with finances if I remember. I think that's all I need to say. I'm happy to answer questions.

Berridge: Thanks very much to our three panellists. Let's open it up to comment now and other people's memories of the time. We are starting in the 1980s, which was when some of

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<sup>14</sup> Michael Howard, Home Secretary 1993-1997.

these issues were all coming onto the agenda, so I wonder if there's anyone here who has particular memories of the 1980s? Hilary?

Dr Hilary Pickles: I was head of the AIDS Unit from 1986 for a couple years to 1988. My memories are only really of the late 80s, so I've been in a time warp, but I've not done any homework on this. Anything I remember will be from that time period. And it was before HIV, it was HTLV-III I think, and during that period HIV was discovered.<sup>15</sup> Already we had the screening of the transfusion service, so we were aware of a virus, of the main methods of transmission, but it was a very rapid time in policymaking and a very exciting time, very exhausting. There was a Cabinet Committee, HA [Home Affairs],<sup>16</sup> and it's now 30 years – I'm slightly constrained as an ex-civil servant to know what I can talk about. But I'm aware there's a lot of other stuff that went on that Virginia missed in her early study,<sup>17</sup> and it's really on the more political side, things that the external advisors wouldn't necessarily know that went on. I'm just waiting to be able to show her which bits of papers to look at when they all get released!

My recollection from that time period was that the prisons were a problem and they were falling behind everything else. Donald Acheson was the Chief Medical Officer [CMO] and he was Chief Medical Officer of Government including the Home Office.<sup>18</sup> John Kilgour was head of the medical grouping within the Home Office and we used to have regular meetings.<sup>19</sup> But actually it felt all along that the prison service was sort of dragging its feet in making progress. The issue about knowing whether someone was infected or not of course was acute in the health service where people were handling bodily fluids from patients. Healthcare staff wanted to know too, just like the prison officers, whether somebody was infected or not. Actually through the power of the personality of the Chief Medical Officer as well as the

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<sup>15</sup> HTLV-III, or Human T-Lymphotropic Virus Type III, was one of the early names for a virus associated with AIDS. It and other early names were replaced by HIV in 1986.

<sup>16</sup> An interdepartmental Cabinet Committee on AIDS was set up on 11 November 1986, and somewhat unusually, the media were informed. See Norman Fowler, *Aids: Don't Die of Prejudice* (London: Biteback Publishing Ltd, 2014), pp. 15–17; Virginia Berridge, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford: Oxford University Press, 1996), pp. 105–7; Peter Hennessy, *Whitehall* (London: Secker & Warburg, 1989).

<sup>17</sup> Virginia Berridge, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford: Oxford University Press, 1996). Civil servants in the AIDS Unit were prevented from speaking to Virginia Berridge during the research for this book.

<sup>18</sup> Sir Donald Acheson, Chief Medical Officer 1983-1991.

<sup>19</sup> Dr John Kilgour CB, Director of Prison Medical Services c.1983-1991.

advisory committees, we eventually came up with agreeing on universal precautions. That was not easy: the Health and Safety Executive said they had legislation on their side for why workers should know about infected people. It wasn't allowed in the health service, but it was difficult to then transfer that to the prison service.

My distinct recollection of that time is that the Prison Officers Association was really, really difficult, and prison governors were very reasonable and some of them were quietly doing things on their own that they were getting away with. I mean, you talked about harm reduction in terms of drugs and of course we did some tremendous stuff later, but my recollection right at the beginning is that the drug misuse community was very much against needle exchange and so on. Indeed, there was a bit of a battle within the Department of Health until in the end we got the policy that we are familiar with now, but it was not straightforward at all. In prisons I certainly remember us talking about the supply of bleach, since somehow the supply of needles was a no-go area.

That, in 1986/88, was clearly something that we were discussing. The details will be in the Cabinet papers that you will be able to get access to in due course no doubt. Condoms as well: I remember being really very surprised to find that condoms could be a lethal weapon! We were obviously talking about the supply of condoms and I was told that actually, although sex between consenting men was legal, it was only legal in private and there's no private place in prison and therefore we would be aiding and abetting a crime to provide condoms, and besides they could be lethal weapons. That was a reason that was given to us at the time. It's the only thing I remember because of my time warp, but in spite of that I think some prison governors and somehow their staff were doing some really rather good stuff on the side.

I think it's difficult to know who were the movers and shakers in all this, but I think we were very lucky in the Chief Medical Officer, because he was able to do things across Government that were not possible for anyone else. The other unsung hero is Robert Armstrong. It sounds silly: he was the Cabinet Secretary.<sup>20</sup> But remembering it was Margaret Thatcher who was the Prime Minister, there were some astonishing things that took place and it was Robert

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<sup>20</sup> Sir Robert Armstrong, Secretary of the Cabinet 1979-1987.

Armstrong who was working within the Cabinet Office and the HA, the first time they admitted there were cabinet committees. I think Norman Fowler did a press conference after the first one.<sup>21</sup> I was part of the secretariat of that and that was a very influential body of senior ministers across Government. I think a lot of the sensible decisions that were taken at that time, which were very brave politically, were because of the leadership of those senior ministers. I remember Geoffrey Howe in particular just being immensely effective.<sup>22</sup> Willie Whitelaw was just the Chair;<sup>23</sup> but actually it was some of the other ministers who made the running. I'm not sure who was Home Secretary, but for me one of the real contrasts was with a parallel committee, where we had permanent secretaries who were completely reactionary.<sup>24</sup> Each was battling for the rights of their own little department. So the two committees were supposed to be meeting in parallel, and instead of the ministers following on from the permanent secretaries, the permanent secretaries were way behind the ministers in their thinking.

Around all of this, obviously it was a big issue in prisons and I'm sorry we haven't got Ken Calman here.<sup>25</sup> I know he wasn't CMO in Scotland yet at the time but I felt that something helpful was happening in Scotland in some places, certainly later on in Scotland. That was the time that I remember. An awful lot has happened since then, but for me the politicians were very important. The Chief Medical Officer was important, John Kilgour as head of the prison medical service was doing his best in very difficult circumstances and he didn't get much support from within his department. And then I left the area in 1988, so there's my time warp.

Ms Andrea Kelmanson: I'll roll in on the bend of 1988. I'm Andrea Kelmanson and I was a deputy director of the National AIDS Trust [NAT] from 1988 to 92, so I roll in at the tail end. I was just struck about the condom story because I have a suspicion that I may know the root of the condom as a dangerous weapon. I don't know whether this is true, but I do know that there was a very famous assault by Borstal trainees at Feltham, a long time ago, when Mary

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<sup>21</sup> Lord Norman Fowler, Secretary of State for Social Services, 1981-1987. See note 14.

<sup>22</sup> Sir Geoffrey Howe, Foreign Secretary 1983-1989.

<sup>23</sup> Viscount William Whitelaw, Deputy Leader of the Conservative Party and Leader of the House of Lords 1983-1988; Chair of the Cabinet Committee on AIDS.

<sup>24</sup> The Home Secretary in 1986 was Douglas Hurd.

<sup>25</sup> Professor Sir Kenneth Calman, Chief Medical Officer in Scotland 1989-1991, and England 1991-1998.

Ellis was the chief medical officer there. It was an assault with billiard balls inside a sock, and they did some terrible things to some prison officers, and that had filtered around the entire universe, as a kind of mythology in that closed world of prisons. I have a horrible feeling it may still have lingered.

I was interested to hear from Ruth that there were guidelines in 1985, so maybe we can come back to that in a minute. The National AIDS Trust was funded 50% by Robert Maxwell and 50% by the Government: the Government put half a million in and Robert Maxwell put half a million in.<sup>26</sup> I think it was in 1987, but I'm not completely sure. Norman Fowler was the person behind the Government money coming in. I had had some experience of working with the prison system before I went to NAT because I used to run some programmes for community service volunteers with young offenders, particularly with Borstal trainees. It became very clear while I was there [at NAT], I felt like there was nothing happening at all in prisons. We were really concerned that nobody was having a conversation. I managed to pursue some of the contacts that I had, one in particular was a guy called Colin Allen, who was by then a member of the [Prison] Inspectorate.<sup>27</sup> So I had a conversation with Colin about the possibility of our putting, they used to have guest inspectors, attached to the Inspectorate and so I remember talking to him about whether there was a possibility that we could have an HIV/AIDS special inspector attached to the team. I believe, and my memory is very vague, but I think Steph Sexton did a number of inspections with them, with that hat on.

The other thing that we did is we set up something called the AIDS in Prison Forum. It just felt really important to have a place where people who had some sort of involvement with this could at least begin to have a conversation. I don't know what happened to it because I left in 1992, but I know that Steph carried on with the work. I just remember being immensely frustrated, as I always had been with any contact I had with the prison service, with this denial,

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<sup>26</sup> The National AIDS Trust was founded in 1987 by the Department of Health, to fund and co-ordinate the work of the many organisations that were springing up in response to HIV/AIDS. Robert Maxwell had promised to match government funding of £500,000 and was photographed handing over a cheque, but no money initially materialised. After a number of hostile stories to this effect in *The Sunday Times*, Maxwell's £500,000 was paid to the NAT in early 1988. Berridge, *AIDS in the UK*, pp. 189–90.

<sup>27</sup> The Prisons Inspectorate was founded in 1981 to conduct independent inspections of prisons and to report on their findings. Colin Allen had been a Governor, most recently of HMP Holloway, before joining the Inspectorate in 1989.

that whole political thing that we mustn't own up to anything that's going on. It was just so incredibly depressing, and it felt like there was a huge mountain to climb, because there was simply no acknowledgement of drug use in prisons, absolutely. It was just not being acknowledged, even though everybody knew it was happening. There were these endless conversations about bleach. I remember having a conversation about bleach with Len Curran, who I think died some years ago.<sup>28</sup> There was just painful struggling about whether it was possible to think about having bleach and all that stuff. That is probably the extent of my memory, which is pretty ropey.

Mr John Podmore: Perhaps if I could share operational prison governors' experiences? I joined in 1985 and left in 2011. In 1985 I do remember VIR, and there was also a file marking for people who were seen as a suicide risk: 'F', that was it. We were very much into marking people out. I recall the separation, fears of drinking out of the same cup, but we actually got through that reasonably well. Yes, the POA were always difficult. The POA I think in those days didn't want female officers on the landing, so there were a number of battles going on there.

I was a trainee assistant governor, I was going through the ranks and training and so on and so forth. This was the days of senior medical officers and there were some very good ones who I learned a lot from, and I knew at least one who ended up in prison. I knew some others who perhaps should have done! But I think as trainee managers working our way through, we had a lot of training and we had a lot of conferences and I don't recall much about that. I think it was up to us to seek out where we needed training. By the mid-1990s, I was at Belmarsh and actually was running the place. That was the time I lost a couple of cat[egory] As<sup>29</sup> and Richard investigated me and I think my career hung on his findings at that time. But my preoccupation there was cat As and IRA.

I suppose a big turning point for me was I then found myself at Swaleside, and I inherited a contract with what was then, it wasn't Addaction, I forget the name of Addaction before it

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<sup>28</sup> Len Curran, Senior Psychologist with the Prison Service, took the lead on much of their HIV/AIDS work in the 1980s and 1990s. He chaired the HMPS AIDS Advisory Committee. He died in 2011.

<sup>29</sup> Category A is the classification given to prisoners whose escape would present the greatest risk to the public.

became Addaction.<sup>30</sup> It was a small drug contract, and it was then that I began to get exposure to many of the issues and was working with the charity, working with drug workers in the prison. That for me as a governor, who by then been in charge of a couple of prisons, was when I was beginning to understand some of the issues.

I then left and joined the Inspectorate and was leading inspections with specialist inspectors and I came across these guys [at Cranstoun] and a range of others. I think that was the first time I grasped the term harm reduction. My whole thinking then was beginning to develop. I don't want to do the service a disservice, but it was by accident rather than design. Certainly, you know, I joined the Inspectorate at the time when David Ramsbotham was doing 'Prisoner or Patient?'.<sup>31</sup> I was around then, and by the time I left the Inspectorate I was into running Brixton and the transfer to prison health, a marriage made in heaven, or a forced marriage. It worked out quite well in Lambeth because everyone in my prison was going out to live in Lambeth and we had a kind of synergy there. That's probably taking us beyond the time we want to look at.

I do recall getting into the debate about needle exchange and there were a number of us who were saying 'This is perfect'. We knew the political dimension because there was a political dimension to all sorts of things in those days, but I think there were many of us saying, 'Well, this is perfectly reasonable'. The question was how much needle use there was in prisons; it was anecdotal, I don't think we ever really, really knew. I think we maintained it wasn't very much. Certainly in terms of stigma, I remember in 2004/5 I was working out in Mauritius and they were proudly announcing that they had got the funding to build a new prison which was going to be occupied entirely by people with HIV/AIDS, such was the problem there. So I realised we'd come a long way. Moving on from there and working with Mary [Piper], there

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<sup>30</sup> Addaction was founded in 1967 as the Association of the Parents of Addicts, and rebranded as Addaction in 1997.

<sup>31</sup> Lord David Ramsbotham was Chief Inspector of Prisons from 1995 to 2001. Upon taking up the post, he was surprised to find that the prison medical service was not part of the NHS and 'set about campaigning to get it incorporated'. The first step in this was a report on prison healthcare, published in 1996. David Ramsbotham, interviewed by Janet Weston, 27 February 2017, and David Ramsbotham, *Prisoner or Patient?* (London: Home Office, 1996). Interview recordings/transcripts from this project are available through the London School of Hygiene & Tropical Medicine Archives.

was lots of other stuff around harm reduction. I hope that's helpful, just a quick canter through my experience.

Trace: John, do you remember anything of the position of the Prison Governors Association in the late 80s or 90s: did they do any work on it or not? I don't remember them saying anything.

Podmore: I did resign in the mid-90s. Ian Dunbar started the Prison Governors Association and I think it did start as a BMA for prison governors, or that was the aim. I think it lost that over the years. I don't think it really picked up that kind of policy debate.

Trace: It wasn't a voice in this?

Podmore: No. The Prison Governors Association was only ever what prison governors made it. I think in terms of prison governors' exposure to the wider issues, I can only speak for myself, but that came with exposure to people like Addaction and then people like yourselves [Trace and Pertica] when I was in the Inspectorate. I spent a long time in the Inspectorate thinking 'Gosh, I've run a few prisons and now I'm inspecting them and I don't really know much what was going on'. For me it was a real learning curve.

Kelmanson: That's an astonishing thing to say isn't it, it's the different spectacles isn't it.

Podmore: Yes, but you know, I was working with Ofsted, I was working with specialists in drugs. I think there are real issues in terms of where we're at now. I think there are real issues in terms of, what are the skills and competencies that a prison governor needs. We were talking earlier: you can't get a governor to go to Belmarsh any more, for a whole variety of reasons. There are issues around skills and experience, and I think that any prison service should be thinking about its risks, the whole threat assessment really, in terms of those skills that people need.

Dr Mary Piper: I'm Mary Piper. I started in prison health as a public health trainee in 1993, and I think for me the most important thing is to put into context exactly how isolated the

prison medical service was, and how the rest of the health community had left prisons to their own devices. At the time the transfer to the NHS was negotiated, the whole budget for prison healthcare was £140 million, and that was in 2000. At each prison there was not a budget: each prison governor had to do his work and negotiate how much would he spend. This was a very isolated group, and as you have heard, there were some remarkable people. The other person I would like to mention would be Rosemary Wool. Rosemary was the Head of the Prison Medical Service and she was just quite an inspirational woman.<sup>32</sup> And I remember, she was very mild mannered, but I think she did something after that debate at the Prison Board, on condoms, because I think she'd probably think to herself 'Well, this is a clinical matter, so it will be dealt with clinically', which is what I think she did do.<sup>33</sup> So it was one of those times when you ask for permission, you don't get permission, but you then carry on. She was inspirational. And also Len, obviously Len Curran worked hard.<sup>34</sup>

So those would be the things that I would say, that this was a group of people who, in the whole of the time I've worked in the public sector, I have not had the privilege to work with people more decent and willing to make a difference. Vis a vis the politics, I'm really not sure. There was never a conspiracy theory in these things. Probably people just didn't have the money. You know, why was somebody going to put money to a survey in prisons when we could do something else?

But actually, as I say that, there *was* a study wasn't there? I can see it now. That was done by the PHLS [Public Health Laboratory Service] as it was, and I could almost give you the

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<sup>32</sup> Dr Rosemary Wool, Director of the Prison Medical Service and then Director of Health Care for Prisoners, 1991-1996.

<sup>33</sup> Dr Wool issued a Dear Doctor Letter to HMPS doctors in 1994, which advised them of the 'first recorded case of HIV transmission within the English Prison Service', by sexual contact, and reminded them that they had 'clinical freedom to prescribe pharmaceutically or otherwise to protect the health of individual prisoners'. In 1995, after the AIDS Advisory Committee had recommended that condoms be made available within prisons and this had been rejected, she wrote again to prison doctors in clearer terms. The 1995 letter stated: 'The purpose of this DDL is to make it clear that prison doctors are free, in the exercise of their clinical judgment, to prescribe condoms for individual patients. The capacity to prescribe within prisons is indeed likely to reduce the likelihood of a prison doctor being found in breach of his/her duty of care if a prisoner/patient contracts HIV in prison.... The burden of our legal advice is in fact that there may be a legal risk in not providing condoms in the relevant set of circumstances through a failure in the duty of care.' The 1994 DDL is quoted in full in Hansard, 'Written Answers: Transmission of HIV within the Prison Context', 1994, vol 244 c271W, and the 1995 DDL is quoted in full in *R v Secretary of State for Home Department Ex Parte Glen Fielding* [1999] EWHC (Admin) 641.

<sup>34</sup> See note 28.

prevalence figures. There would be the prevalence there for HIV, which I think was probably in the region of 6%, increased in those who said that they were injecting drug misusers.<sup>35</sup> I could give you all of that. So there was a study done. One worked to the best that you could.

The bleach saga, I mean lest anybody think that that stopped with the transition to the NHS, you have to be joking! That saga went on for, goodness me, your colleague here did a study, Kaye Wellings did a study, we tried an implementation study, what was that, in 2004 or 2006.<sup>36</sup> But the perennial argument was always ‘Oh, there’s going to be an explosion’, or that these were going to be a fire hazard, or that people were going to make bombs out of them. I can remember once being rung by somebody who said that they’d snorted them, to which my reply was ‘Well, they won’t be doing that again will they’. So there was an awful lot of risk-taking and brinksmanship around it.

Podmore: But to be fair, Mary, there was always that within prisons anyway. You know, you could measure almost anything in prisons and there’d be a paranoia about it.

Piper: Yes, and you can understand when you’re an isolated unit, and the media and the headlines are there for tomorrow’s news.

Podmore: I’d drink my morning coffee out of a mug made on a kiln, which was two cells on B wing in Brixton: I’m sure that probably would [be seen as dangerous]. But it was an important issue – I said the turning point for me was the bringing in of the drug services organisations, and this was something that you [Piper] cured albeit many, many years later, but this split between the clinical budget and the programmes budget. There was the prison service drugs strategy, which held the budget for the programmes, which was separate from the clinical. Now, when I joined you in health and you were working on the nonsense of that, it was the

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<sup>35</sup> A R Weild and others, ‘Prevalence of HIV, Hepatitis B, and Hepatitis C Antibodies in Prisoners in England and Wales: A National Survey’, *Communicable Disease and Public Health*, 3.2 (2000), 121–26. This study found that the prevalence of HIV amongst men in prison was 0.3%, and amongst women, 1%. The figure of 6% was the prevalence of HIV amongst men in prison who had had sex with a male partner in the previous 12 months.

<sup>36</sup> Professor Kaye Wellings, professor of Sexual Health at the London School of Hygiene and Tropical Medicine, led an evaluation of the pilot programme of disinfecting tablets in the late 1990s.

Patel Review; was it 2007 or 2008 before we actually got rid of that.<sup>37</sup> But I think that was a barrier to a better strategy and a better way of dealing with the issues in prison.

Piper: I just want to say, if you think you've cracked it now, I don't think that is the case. I think we are going backwards now. There was a peak, maybe 2000, no, 2010, when things were going forwards. They are going backwards.

Kelmanson: Nothing you say to me about the prison service going backwards would surprise me at all, but what's going backwards?

Piper: I'm talking about the health service: the healthcare of people in prison is going backwards because of the necessity to commission, which doesn't really reflect a quality service being provided.

Mr Paolo Pertica: I'm Paolo Pertica and as Mike mentioned before, I joined the Parole Release Scheme in the very early 90s. Just a couple of memories I wanted to share with you. One, and forgive me, those who worked in the community, but I would just like to clarify that so far we are being rather critical of the prison service and what prison services did in relation to HIV/AIDS. But if you look generally at dealing with drug users, even in the community, it was actually AIDS that made services change. Before HIV/AIDS, the only services that you would get in the community, was to get yourself clean. I just wanted to put it into context, that the community was not a beacon of best practice at the time.

I had the pleasure of being one of the first drug workers to do shared care with Dr Claire Gerada in Wharf Road in the late 80s/early 90s.<sup>38</sup> The only reason why that happened, the provision of needles and methadone and shared care, wasn't because all of a sudden people felt empathetic to drug users. It was only because people didn't want their own sons and daughters, uncles and aunties, to catch HIV, and if that means we need to give them

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<sup>37</sup> Professor Lord Patel of Bradford was Chair of the Prison Drug Treatment Strategy Review Group. *The Patel Report: Reducing Drug-Related Crime and Rehabilitating Offenders* (Department of Health, 2010).

<sup>38</sup> Dr Claire Gerada worked at the Caravan Needle Exchange at South Wharf Road in Paddington in the late 1980s, providing primary care. She went on to work in general practice in south London in the 1990s, and became Chair of the Council of the Royal College of General Practitioners in 2010.

methadone and needles and condoms, then so be it. Just to put it into context, that the prison service were operating within a community which was not that much better in my opinion, from an ethical point of view anyway.

The few bits that I want to share with you, that perhaps nobody mentioned yet, is that we heard Mary talking about [HIV] prevalence of 6%. The agency that Mike managed dealt initially with just sentenced prisoners and then Mike developed the remand unit, to implement the Criminal Justice Act of, I think, 1991.<sup>39</sup> I have to make the same apologies, it's many years ago so my memory also may not be as reliable as I would like it to be! I started to work as a remand worker in the London prisons, and the bit of work which I developed further with the support of Mike, was to work with foreign prisoners, because in Brixton prison you had the highest levels of Italian, Spanish, Portuguese, French, and North African prisoners. As you can gather, I speak a bit of broken English, I speak a bit of Italian, I speak a bit of broken Spanish, I'm not sure how I learnt it, perhaps I spent quite a bit of time in Barcelona in the 80s, and I speak good French. So I became the foreign drug man of Brixton prison. The prevalence of HIV amongst the foreign prisoners was shocking. I saw a figure of 20, 30, 40, 50%. So I just want to share with you that when we're saying maybe there hasn't been an epidemic within the prison service, maybe we don't know there has been one. Although the prevalence rates amongst English prisoners was very good, because of the work of the Department of Health in the community, if you look at the prevalence of HIV amongst foreign prisoners, it was considerably higher. Inevitably, these people shared needles with other prisoners and in some cases, God forbid, they might even have sex in private corners of the wings. I think that's an aspect that, if your research could look into it, it might find something interesting.

The other thing I wanted to share with you is that most ministers didn't want services [for prisoners], and most governors didn't want services. I remember walking in and out of the prison every morning and saying good morning to the governors. They knew what we were

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<sup>39</sup> The Criminal Justice Act 1991 introduced Drug Treatment Orders for offenders over 16 deemed to be dependent on drugs and likely to respond to treatment. They depended upon the availability of local treatment facilities, and required specialists in prison remand wings to assess who might benefit from treatment and to find places for this treatment in the community. Mike Trace and colleagues were involved in delivering these services.

doing. The difference is that we were funded mainly by health authorities and probation services and trusts and a few other grant-giving organisations. But they knew full well what we were doing, so it's not that they could pretend they didn't know that it was happening.

I shared a memory earlier on with Mike and John [Podmore] about some prison officers who didn't like us being there. During one of the alarms, one of them pushed me in a cell and locked me with a Number 1 (and if you are not familiar with the Number 1, it's the most trustworthy prisoner in that wing) to try to scare me off, because they didn't like me being there. But the governors knew full well what we were doing, the work that we were doing. I think that this denial, it may have been at the political level, the media level, but they knew full well what was going on in their establishments because they saw us coming in and out every day.

One thing that I remember that stuck with me, particularly in Brixton prison, was that the then Lambeth, Southwark and Lewisham Health Authority provided us with funding for an HIV coordinator. It was possibly, I'm not sure, the first one ever in a prison. I happened by then to be a manager, and I was managing this colleague of ours. The one thing that remained with me was that those prisoners who were receiving antiviral treatment in the community, when they were arriving in prison they had their treatment interrupted. I'm not medically trained, but apparently that is the worst thing you can do: like with antibiotics, if you start the treatment you should finish. So that stayed with me. I think that a lot of people expressed and articulated, perhaps disappointment is not a strong enough word, that it was happening. Obviously, some of these people were not found guilty and they would have been released from remand. So their treatment had been denied, even though actually they were not found to be guilty. That was quite upsetting, in my opinion.

And another observation which has been made earlier, was about different senior medical officers. I don't know in relation to HIV/AIDS, but in relation to drugs it was a really interesting aspect. I worked in Brixton, in Wandsworth, in Belmarsh, Holloway, in Feltham Young Offenders' Institution, which was probably the most upsetting environment I've ever worked in in my life. And every single medical officer had a different drug strategy. In one prison you would receive methadone, in another one you would get DF118, in other one you would get

some other substance.<sup>40</sup> In Brixton at some point they were allegedly giving people electric shocks to help them with their drug withdrawal symptoms. It was a bit weird, how the senior medical officers seemed to have complete independence in what they could do, rather than somebody deciding what would have been the optimum treatment.

For me, the other thing is that the theory is that it should be policy that informs practice, but I would agree with Mike that during those years there was a lot of good work that did the opposite. It was the practice that eventually started to inform policy development. Not just because he's a very good friend of mine, but you got governors like John [Podmore] who was very avant-garde in his thinking and willing to do things differently, and many other colleagues who have been mentioned and others who haven't. I don't know if some of you will remember Eddie Killoran, who regrettably is no longer with us. He worked at Turning Point and then joined John in the Inspectorate of the prison service, and he had a pivotal role in developing policies for both drug treatment and HIV/AIDS in prisons.<sup>41</sup> But, from my direct personal experience, I think another thing which would be interesting to look into is the impact of foreign prisoners in the London prisons.

Kelmanson: I'd really support that about the foreigners in prison, because I'm fairly sure that NAT either funded or talked about funding some projects that were focused on, I'm fairly sure it was Italians actually, but I can't remember the detail at all. But I really remember exactly what you're saying.

Pertica: I would have to be careful, but I think, from memory, the first person to ever die in a prison of AIDS was an Italian prisoner. In Clerkenwell there was Father Carmelo, a priest.<sup>42</sup> I don't want to sound too dramatic, but the amount of funeral trees which I'd plant in my garden because of Italian parents coming here to the funeral to bury their children from Italy, it was quite worrying.

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<sup>40</sup> DF118 refers to dihydrocodeine, an opioid painkiller.

<sup>41</sup> Eamon 'Eddie' Killoran, a former drugs user, worked with Turning Point and Addaction over the 1980s and 1990s before joining the Prisons Inspectorate under Lord Ramsbotham. He died in 2006.

<sup>42</sup> Father Carmelo di Giovanni, a Pallotine priest who was based at St Peter's Italian Church in Clerkenwell throughout the 1980s, 1990s, and 2000s, and worked with Italian prisoners in the UK.

Kelmanson: And we were really aware of that.

Pertica: Mike and I created a network of agencies in 1994, working with foreign prisoners, funded by the European Commission. I had the tough job of having to travel throughout Europe to find somebody else who worked with foreign prisoners, and we then created this network and we would organise annual conferences, to try for everybody to share good practice. If you recall, in 1994 free movement started, so whereas before you would have to have a visa to move from Spain to England, from England to Germany, all of a sudden that was no longer the case: everybody could move. Having learned what was going on in Brixton prison even prior to that occurring, we had this view that by moving the general population there was also going to be greater movement amongst problematic drug users, which would have led to an increase in foreign prisoners, because obviously many of them would be doing crime to support their drug addiction.

Trace: I'd forgotten entirely about that, but the fact that we created the job that you [Pertica] ended up doing was our reaction to the fact that a lot of the guys we were meeting on the wings were your prisoners. I forgot we did that job! We, as a small organisation, as a service provider, we created a role. I think it got funded by City Parochial or whatever, explicitly for that.<sup>43</sup> We must have been reacting to what we were seeing on the wings.

The other thing I remember is, in 1994, when we started networking with other countries, expecting to find lots of British prisoners in other prisons, we found we were a net importer of Mediterranean, Spanish, Italian, Greek, Portuguese. So there was something— does anyone remember when free movement started? – there was definitely an influx of young people from those countries who were getting involved in drug scenes, definitely in London. I don't know about other cities. They were at the wrong time and the wrong place, because they were injecting and subject to these risks.

Pertica: There were a lot more complex problems, because it goes without saying that most of the local prisoners, irrespective of how local they were or not, would have had family

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<sup>43</sup> The City Parochial Foundation, a charity tackling poverty and inequality in London, now known as Trust for London.

support networks, they would have been registered with a GP in the community. The difference is that all these foreign prisoners had no family contacts here, they had no support network. There was this criticism by organisations such as the *Daily Mail* saying they were coming in here, to benefit from the benefit system. We did a small piece of research, and 75, 80% of them weren't in receipt of even the benefits they were entitled to. Most of them had no GP. I remember spending loads of hours in Brixton trying to explain to them that a probation officer was not a police officer pretending not to be a police officer, because in Italy for example it didn't exist at that time, the probation service. They actually came to England to learn how to create one. So every time an Italian prisoner saw somebody in plain clothes saying 'Look, I'm not here to do anything, I'm a probation officer, I'm here to help you', they'd go, 'Yeah, yeah', and they always said to me, 'Police, police...'. And I'd say 'No, no!'. There were all these challenges, which, if the life of an English speaking prisoner with a lot of support inside and out was already challenging, because it was, being in prison, if one was a foreign prisoner, it was a lot worse for all those reasons.

Mr John Dring: I'm John Dring and I was a governor in the 1980s, when this started, and my memory is very vague, like everybody else round the table I guess. But there were so many issues involved in running a prison at that time, I don't remember HIV as being a very worrying one. It raised its head once or twice. I remember the POA, who were a force to be reckoned with in most prisons. If we were thinking about changing things, which we thought about all the time, we'd have to work out how you'd get it past the brothers, in order to get it into action.

I was at Featherstone prison in 1985/86 and a bit of 1987, and then I was at Aylesbury for long term, young offenders who were mainly from London, all doing seven years to life, all under 21, a fairly violent and disturbed population. I got to Aylesbury in 1987 and I remember some conversation with the POA committee who were getting concerned about identifying of HIV prisoners. I can't remember really how we managed it. But the thing that strikes me is at Featherstone and in Aylesbury we had a part time doctor, in other words a GP, so the NHS was already in my prisons. And I think they managed it in much more of an independent way than maybe a prison medical officer, a full time member of the prison services would have done, guarded as they were by hospital officers, who were also members of the POA and not

terribly confidential about patient confidentiality I suspected in many places. I just don't remember it being a big issue in either Aylesbury or Featherstone in the 1980s. Maybe later it might have been different, but at that stage it was just one of many problems. As far as I know, the GP was issuing condoms, but it was all done as 'Doctor, that's your area, you manage it, I don't want to know, don't tell the POA and just get on with it'. That's I think how we muddled through.

Tilt: Can I just put in my experience at the same time as John [Dring] as a governor. I was governor of Gartree at pretty much the same time, and I agree entirely with your comment that it wasn't a huge issue, or wasn't at that time. It became a huge issue at Gartree because we got selected - I don't quite understand how - for this first special unit. At that point, we hadn't got to having people identified with AIDS, but the service was clearly expecting it and felt that it needed to make special provision. So we had a unit created in Gartree, I think probably because we had some spare space in the hospital area. A lot of money was spent on this unit: it was cells with special paint on the wall which you could wash very easily with all these high pressure things put in, so you could hose people down. And this is before we had anybody.

Kelmanson: Were people ill?

Tilt: We hadn't got people who were ill. I think it was about 1984, but I'm not absolutely sure, it might be 83. This was, as it were, contingency planning. We knew about AIDS. The prison medical service thought this is going to be very difficult: how are we going to deal with these people? We'd best deal with them by segregating them in some special unit. I think there were others created, but Gartree was the first one as far as I know. We put in all this special equipment and all the protective suits were provided for staff and of course in hindsight one can see how unnecessary all that was. The problem is of course that it simply raised the tension and the emotions of staff who were working at Gartree. When they saw all these preparations being made, they were bound to think 'Gosh, this is really dangerous'.

Pickles: It was universally fatal at the time. There was no treatment and there was no testing either, at the time.<sup>44</sup> So I think that probably might have been happening in the health service as well.

Kelmanson: At the time, did they know yet how it was transmitted?

Pickles: No.

Kelmanson: So, basically, they thought it was the plague and that's the best way they could deal with it.

Pertica: The police in the community in the mid-1980s were using gloves, if they were dealing with a problematic drug user.

Tilt: Certainly the first sort of stuff that came on television, the police started to wear protective suits for dealing with people who either had, or were suspected of having it, and of course all our staff saw that.

I'll tell you, well, it's not a story, it's actually what happened and it's quite interesting. I would want to redress the balance for the POA slightly, in terms of what has been said. This unit stood empty for some months, I think, and then I got a phone call one morning saying 'We've got a prisoner on his way from Norwich with AIDS'. Well, I let the POA committee know, for the reasons that John [Dring] said: it was significant. They called an immediate staff meeting which went on for quite a long time. Before the staff meeting came to an end, the prisoner was outside the front gate in the van and was not being admitted because of the POA position. The meeting went on most of the morning, and when it ended the POA committee came up to me and I believe that they said 'We've tried very hard to persuade the staff to accept it, you know; we understand that precautions have been taken, and we think it is reasonable for

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<sup>44</sup> Early forms of HIV test had been developed by autumn 1984, and were mainly used to test haemophiliacs and medical staff, but at this stage the meaning of a positive test result was not entirely clear as the precise relationship between HIV and AIDS remained uncertain. Two UK licenses were granted for HIV tests in late 1985, and both the types of test and knowledge surrounding the results improved further over the next few years. See Berridge, *AIDS in the UK* (Oxford: Oxford University Press, 1996), pp. 46-49.

the prisoner to be admitted, but the staff simply will not agree'. And we got into a discussion about all this and they said to me, 'Would you come down and talk to them?' So I went down. The staff were all still assembled, and the prison was locked up, and I went down to talk to them. It was a pretty hostile meeting. I spent fifteen or twenty minutes really trying to make the moral case for treating people reasonably, irrespective of what their medical problem was, and then left and the POA committee had another vote. Curiously the staff then voted to admit the prisoner. And we did admit the prisoner, and there wasn't a problem. The issue went away after that.

Pertica: But again, if I may, this is the days of the advert with the tombstone.

Tilt: It was before that, because I was going to talk about that.

Pertica: Okay, but what I suggest is that there was a very high level of fear within the community. Nobody knew what the transmission routes were. I think it's easy with hindsight to say 'Oh come on, unless you have sex with them or share a needle you will not catch it', but in those days nobody knew.

Kelmanson: Absolutely. I remember the HEA, the tombstone thing happened at the time I went, in 1988 actually.<sup>45</sup>

Tilt: I just want to make the point that, in the Gartree situation, the POA committee were entirely reasonable as far as I was aware. They were a pretty reasonable bunch anyway on most things.

Trace: But it's important to remember there were several years where a lot of these decisions had to be made, where transmission routes and what we now know to be best practice, were undergoing heated debate. I remember Swedish colleagues around then, they had a carceral island.

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<sup>45</sup> In early 1987, the government launched a memorable television campaign to raise awareness of AIDS, in which the letters AIDS were chiselled onto a tombstone. See Appendix 2.

Pickles: And no treatment other than symptomatic treatment. A death sentence if you were infected with it, and you were going to die within two years, sometimes within a few months.

Trace: That wasn't just a few months of uncertainty. That went on for a long time.

Pertica: For me, I think it's obviously good and wise to acknowledge the shortcomings, and what was not good practice, but I think it's important to put it in the correct historical context. Why didn't they in the Victorian days realise it was not a good idea to mix drinking water with the sewage? It seems common sense now, but in the 1820s they didn't know that and everybody was dying in the streets of London. I'm not suggesting that the prison service couldn't have been more progressive – we can always look at our practice and be better – but I think it's important not to try to dissect what was happening in the 80s and the 90s with the knowledge that we've got in 2017. Don't get me wrong, I'm not here to say that there are not things that the prison service could have done better, because certainly there were, but it's important to consider the context. I remember in the community, all the police officers were given plastic gloves and if they were touching someone they knew as an IV user, they would not touch their skin. They didn't know at the time if you could catch it or not, or the difference in the resistance of the HIV virus and the hepatitis C virus, or how long it would last in a syringe: nobody knew that.

Pickles: In those days, a lot of the workers, the routine work of staff in the AIDS Unit (not that we had many staff) was dealing with this sort of anxiety from members of the public, about whether you could catch it from sitting next to somebody on a bus, or a swimming bath, or a lavatory seat. There was an awful lot of fuss about a doctor who had AIDS and the *News of the World* wrote a terrible series of articles about having to expose this doctor because he was a danger to his patients.<sup>46</sup> So the general public was very confused.

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<sup>46</sup> Health care workers with HIV or AIDS became 'an issue of enormous symbolic importance' for policy-makers: the response to potential infection in this group was an important indicator of how policy would move more broadly, and civil servants were keen to protect health workers from discrimination. Berridge, *AIDS in the UK*, pp. 73–74.

Trace: And at the same time, the effectiveness of things like needle exchange, we didn't have the data. So we knew that it was something worth implementing but the proof wasn't there.<sup>47</sup>

Pickles: I seem to think we had some reasonable evidence. I went to Oslo and I went to Amsterdam and got information from them.

Trace: But to talk to sceptics. Absolutely, all the committees we were on were saying that there is evidence, and the WHO and all that sort of thing, but the solidity of the evidence, the proof at public health level was lacking. Most of those decisions had to be made in the light of 'this looks promising' and 'it's worked in Oslo or Amsterdam'. I can remember we spent a lot of time campaigning saying needle exchange will work, this is what you need to do, but you couldn't bring chapter and verse and you had a lot of sceptics like the POA, who would say that it won't work in prisons.

Kelmanson: I also think that the other theme that I'm very, very aware of was the homosexuality theme, which was really there all the time. I mean, it was still there in 1992 when I left NAT. That was a particular issue, and it shed a particular light for example on some of the young men who come here from Italy or from Spain, in terms of attitudes towards homosexuality in the countries that they came from. I was aware, and I don't know how I was aware, but I was aware that there were some people in the prison service who were anxious about engaging with this issue because they were homosexual. And they didn't, they were ambivalent about it, which was really terribly sad.

Pertica: If I can make a brief comment. You mentioned Amsterdam, and from memory when we did the work in Europe, England and Holland had the lowest prevalence of HIV amongst problematic drug users. So, England was actually the avant-garde, however much we are all being quite self-critical, within the communities as well as in prison. If you compare it with Italy, Spain, France, Portugal, Switzerland, Austria, Germany you were well ahead of everyone else, so there was not a lot of evidence from which to benefit. Unless you were going to

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<sup>47</sup> The first evaluations of needle exchange programmes in the UK were published in 1988: Gerry V Stimson and others, 'Syringe Exchange Schemes for Drug Users in England and Scotland', *British Medical Journal*, 296.6638 (1988), 1717–19.

Amsterdam, which had the first needle exchange in Europe because of the service user group,<sup>48</sup> there was no other practice anywhere. When we formed the network of prisons, it was hard work to actually find one agency within the whole network that worked in prisons.

Trace: That's what I mean about the evidence emerging. What was happening in Amsterdam, Liverpool, around the UK increasingly emerged through the late 80s, and there were reports that said 'They've done this and it's worked'. But in 1986/87 you didn't have all that evidence. So there was quite a period where it was experimental. Well, it felt experimental.

The other thing about the issue, and it's uncomfortable to say it, is about the sub-groups within the HIV campaigning world. We had lots of debates about what was most important, gay transmission or drug transmission. The prisons and drugs thing, as it usually is, is struggling for attention and I can remember it was then. There was a lot of debate about 'Well, is this the most important thing? It's a relatively small number of people', and there was a lot going on around sexual transmission. So in campaigning terms, there was also the same debates: are prisons really important.

Pickles: In the same way as haemophiliacs. We mustn't forget them.

Palmer: I wonder if I could add something now? I'm Jan Palmer and I led the development of the first, what was then a detoxification service at Holloway Prison in 1997. There was political interest in that, and prison health funded that. It was the first NHS-supported service of its kind in prisons and we had a lot of political interest: we kept having ministers and all that coming to visit us.

There were a couple of problems with that. Firstly, I was seconded from the NHS, but this was before the transfer. So there I was, working alone, essentially, without any authority. I was trying to change practice from five days of DF118 and stop, to something more humane in terms of detoxification. The second thing was, that was exactly what had been commissioned: a detoxification service. But after about eighteen months of this work when we had extended

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<sup>48</sup> In Amsterdam, collectives of drug users had begun to form in the late 1970s and were known as *Junkiebonden*. These groups were active in the early distribution of clean needles in response to HIV and AIDS.

the detox to something more humane, and we had treatment etc., we realised that actually detoxing people was not the way we should be going. We should be offering them maintenance, we should be offering them extended regimes, and so on. But we hit a contractual barrier because we had been contracted to detox everybody.

However, despite all those difficulties, that service led the way in terms of development of clinical substance misuse services across the prison estate. It was then ultimately used as the model that underpinned the writing of the Department of Health guidelines, which I did with Mary and others, much later than this – I only retired in 2012.<sup>49</sup> So the bulk of my work is much later, but the early days were quite revolutionary and ground-breaking, and showed up huge issues. The prison service wasn't ready for this at that time.

With regards to HIV and AIDS specifically, it was interesting. About 75% of all women who came through the front door in Holloway at that time would require formal detoxification, that being from drugs or alcohol or both. There were others who were involved in drugs, but didn't need clinical interventions. Nevertheless, the rates of HIV were phenomenally low, very, very low. We had women who would claim to have HIV because that got them privileges. As we've heard earlier, they could have a single cell. I think they could have milk and fruit, from memory, I can't remember but there were some goodies to be had by claiming to have HIV. Similarly there were privileges on release. This is where the Trusts would meet them and help them and do certain things. So we used to get rather caught. It wasn't about not divulging that people were HIV positive, because they used to tell everyone anyway, it was about the fact that certain women told everyone they were when you knew they weren't!

Pertica: It's unique, Holloway, isn't it.

Palmer: Holloway was unique. I remember early, early on we had one serious incident of an assault on our unit, where there was a woman who was HIV positive, who bit an officer and drew blood seriously. There was a lot of blood and saliva contact, so there was a lot of concern and much advice had to be sought before we could divulge to this officer about this woman's

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<sup>49</sup> Department of Health, *Clinical Management of Drug Dependence in the Adult Prison Setting*, November 2006.

status. I was on secondment from the NHS Trust at the time, so the Trust had to seek legal advice, the prison service had to seek legal advice, and oh my God this went on for hours. Eventually we did tell him and we shipped him off to St Mary's Hospital to get some prophylactic treatment. That single incident rather won over the staff at the time in Holloway, and suddenly they were much more behind what we were trying to do and really embraced it and tried to move it on.

They were bitterly disappointed at the same time, because we'd detox people and they were much more comfortable and self-harm dropped if we did it more humanely, but what staff couldn't quite understand is once having detoxed, why did they keep coming back. They never did quite grasp that. But that single incident really did bring a lot of people on board.

There were extensive bleach tablets in use pretty much from when I was first there. I sort of remember them being introduced with a few leaflets, which quickly ran out. All the women loved them, because women like to be clean. So they used them for everything: sterilising the basins, and the wing cleaner when she got to my office to mop my floor used to pop another one in. 'Here you are Miss', she said, 'you can have an extra one because you're the manager'. And my floor was lovely and smelt of bleach every day. We talked about this much later on when I wasn't a prison-based health specialist, but nevertheless we felt that whatever they did with them, they were raising standards of hygiene which had to be a good thing.

In terms of injecting, they weren't at all interested in needle exchange, because when they came into prison they didn't want to inject. They used to say 'It's fine Miss, while we're in here'. Once we'd got proper drug treatment and much more extended prescribing and maintenance regimes, they didn't need to use. But even prior to that, they said 'No, whilst we're in here, we don't want to inject'. That's quite an interesting take, certainly for women.

Condoms were given on release. Women didn't need condoms in prison, but they did need dental dams, and they were provided with dental dams by the GUM clinic, a bit like you were saying, in a prescribed way. We didn't even know who had them. I'm just talking about the three years from 1997 to 2000, and that was how it was then. It changed hugely after that. But I never saw much in the way of injecting in the years that I worked in the women's prisons,

which was for many years beyond that, because they pretty much all said no, while we're in here, we don't want to inject.

Pertica: I remember reliable evidence of up to twelve or thirteen prisoners using the same needle. I don't know how familiar people are, but one thing is to use the needle and then take it out of the vein and rinse it and then somebody else uses it, and the other is that you have got 20 bars [marked on the syringe] and the first prisoner injects four bars, and then it goes to the next one and he injects another four, so he is the second person, then John injects another four, so there is three people, so by the time it gets to Janet, she's injecting the blood of ten people.

Palmer: Except she's a woman so she's probably not! They were fussier! They were very conscious of hepatitis C. Really, HIV didn't get talked about very much. They were much more conscious of the hep C thing and fearful of getting that. Of our 75% of women, a huge number were hep C positive. Although the HIV thing was minimal, hep C was massive. At least 50%, though I can't remember any statistics.

Pertica: It is a lot more infectious and the virus is a lot more durable. The HIV virus within a needle dies in a matter of, I don't know, seconds, but hep C can last for days.

Palmer: Exactly. They were much more worried about hep C. I think, if anything, that probably helped to stop them thinking about injecting while they were in prison. So we wouldn't have had much use for needles in any case, but they loved the bleach tablets.

Trace: Jan, what was the testing regime in Holloway in those days?

Palmer: It was within the GUM clinic, and it was confidential.

Trace: Was it voluntary?

Palmer: Yes, but they used to go. There was a huge uptake. Women like to go and do those things. Fortunately the GUM clinic was just at the top of the stairs from our unit, because

you'd have tribes of women going up whenever the clinic was open. Logistically that was probably okay, but if it had been right round the other end somewhere I don't know what they would have done. When women came into prison, they would have the whole thing, you know: dental, doctors, everything you can imagine.

Pertica: I worked in Holloway and many of them were either mothers already or they were trying to become mothers, so there was a pushing factor because they wanted to be healthy because they wanted to have a child.

Palmer: We had loads of pregnant women. Women on the whole liked to look after their health, and they like to do those things and they like to be clean. Anyway, there was a lot of Hep C, but comparatively very little HIV.

Podmore: Do you think it's worth carrying on reflecting about staff attitudes, starting with Richard and that level of hostility?

Palmer: Can I mention one more thing, because I shall forget – my memory is not what it is was either. We talked about the interruption of treatment for HIV. Where we did have women that were HIV positive, we certainly experienced that, but it was much more about the arrest process. I remember one time a policeman ringing me up and saying they had arrested somebody or other and they'd kept her medication. The woman had then arrived in the middle of the night and we couldn't get any for some time. She would see the doctor on the next day and there was this big delay. Now that wasn't anything to do with the prison, the prison were delighted to continue it, or were willing to continue it, but we couldn't. It was interrupted by the arrest process.

Then, much, much later on and this might have been beyond 2000, there's the timing issue of when you take medication. I think we tried to give women that medication in possession, so they could take it when they needed to, but they found themselves bullied for it. Even though it's not actually going to do anything, because they've got medication, they were being bullied to give it away and that further interrupts treatment. So treatment gets interrupted in prison for a variety of reasons, not necessarily the unwillingness of the prison.

Pertica: Apologies if I suggested that it was because of the prisons. I was saying that it was very upsetting that, whatever the reasons, there was no continuity between being treated in the community and prison.

Palmer: There was no continuity and we were quite upset by it as well, and it was a common thing, but it was usually by the arrest process. Don't forget that people would be arrested and not to come to us for maybe forty-eight hours, during which time they probably hadn't had their treatment.

Podmore: I was going to talk about attitudes. Clearly, they have changed, and we must remember that prison staff reflect outside attitudes. Staff are just members of the community, and I think the whole attitude to AIDS and HIV has changed, not least when it becomes more prevalent in the community and you've got prison officers and their families affected and they're wrestling with it and so attitudes change. We should also reflect on training: I've reflected on training and it wasn't brilliant in this area. Training for prison staff is eight weeks or whatever, it isn't that much.

In terms of dealing with an epidemic, Mary will remember, we worked on the TB epidemic at Brixton, when we had staff and prisoners dying of TB. We got through it somehow and staff didn't walk out. We had a great difficulty getting the X-ray van in through the gate because it didn't fit! But staff under those circumstances were great because they knew a lot more about infectious diseases. Programmes like EastEnders and all that, and it's about how you communicate. But I'm glad I didn't have to make that speech at that POA meeting in the 1980s!

Tilt: It's all about giving people more information, isn't it.

Podmore: Absolutely. And people were frightened, legitimately. As we've demonstrated, prisons see a heavy concentration of these issues, and we sometimes forget just how much concentration there is of these kind of problems.

Berridge: Richard, could you say a bit more about the Gartree unit and what happened to it? Was that first prisoner the only one who was in there?

Tilt: I don't think we ever had more than two or three people in it. It became a non-issue once we got past that first one arriving. As far as I know, I don't think any of the high pressure washing stuff was ever used, as John [Podmore] is hinting, because attitudes did start to shift. People got more information, there was a lot more public information and a lot more attention in the community to it, and prison is part of the community. I must have left Gartree in about 1987 and I think by that stage we had stopped using it, virtually. It was a white elephant, because people were on normal location.

Dring: It became a therapeutic community.

Tilt: Did it!

Pickles: In 1987, when the AZTs started coming in, the people who needed treatment were transferred to the hospital unit in the NHS.

Tilt: Yes, that's right.

Podmore: I think there's an issue that was never addressed, and it's still hasn't been addressed. We talked about issues of homosexuality in prison, and it's only the Howard League that's looked at sexual violence in prison and how we deal with that.<sup>50</sup> The prison service is still in denial on that one. The Howard League did that very, very important paper and had no cooperation whatsoever from the prison service, who say that not only is there no sexual violence in prison, but there probably isn't any sexuality here at all. That was something that was never, ever addressed and as I say, still isn't.

Kelmanson: Is it your view that that's because of political expediency? Is it the politics? Is that the answer about not wanting to acknowledge it?

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<sup>50</sup> Ailsa Stevens, *Sex in Prison* (Howard League for Penal Reform, 2015).

Podmore: It's difficult. It's out of sight, out of mind. The irony is that in the States, which is not known for liberal penal policies, it was George W. Bush who brought in the Prison Rape Elimination Act.<sup>51</sup> Amongst many things, that was saying 'We have a problem. It will happen. We don't know the extent of it. We need to find out the extent of it; we need to be able to acknowledge it; we need to be able to deal with it just as we would in the community'. And they have changed attitudes. This is George Bush in the States, for God's sake. In this country there's complete and utter denial.

Pertica: But for me it's the result of the human bias. I think that's what happens with the prison service. It's not an easy thing for many prison staff and probably for many of us to envisage people practising sexual violence. It's not the kind of thing I wake up in the morning and think of, it's not what I hope for my children, it's not something that, as a human being, you would naturally find easy to comprehend and deal with. So any way that you can tell yourself 'no, this is not happening', to avoid dealing with it, you probably do without being aware of it.

Podmore: I'm at risk of straying off that topic a bit, but I think it's important. I've just done some expert witness stuff in Scotland on a fatal accident enquiry, and it was two prisoners sharing a cell and one killed the other. Now, part of the fatal accident enquiry was to look into the criteria for whether someone should or shouldn't share a cell. I was trying to say to the court that one of the major recommendations from the Mubarek review is the prison service should phase out enforced cell sharing.<sup>52</sup> It isn't: it's building prisons with built-in cell sharing. The Mandela Rules, I think it's number 12, says you shouldn't share cells,<sup>53</sup> but we need to

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<sup>51</sup> This Act was the first federal law dealing with sexual assault of prisoners, and was introduced in 2003.

<sup>52</sup> The Zahid Mubarek Enquiry reported in June 2006 following the racist murder of Zahid Mubarek by Robert Stewart in HMYOI Feltham in March 2000, and made 88 recommendations. The first of these was that enforced cell sharing should be eliminated. Brian Keith, *Report of the Zahid Mubarek Inquiry* (London: Stationery Office, 2006), p. 446  
<<https://www.gov.uk/government/publications/report-of-the-zahid-mubarek-inquiry>>.

<sup>53</sup> The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) state at Rule 12.1 that 'where sleeping accommodation is in individual cells or rooms, each prisoner shall occupy by night a cell or room by himself or herself. If for special reasons, such as temporary overcrowding, it becomes necessary for the central prison administration to make an exception to this rule, it is not desirable to have two prisoners in a cell or room'.

understand that there is a lot of cell sharing in the service. Less so in high security prisons. With that comes all sorts of risks, and when we talk about harm reduction we should consider that.

Kelmanson: I do understand the point that you are making, which is about not having different expectations of prisons than the wider community, or at least recognising that the issues in the wider community are the same. Notwithstanding that, and I think that's sort of right, but there is something doggedly resistant about the prison service. It's to do with the closed community. I mean, I'm sure it's about that, but it's terribly, terribly infuriating even all these years later.

Pertica: You are right. When I worked in the prison service, you were constantly aware of this. You had the care bears and the dinosaurs. The old style prison officers, they were dinosaurs because they were going into extinction, they were gradually getting extinguished. Their job was to lock 'em up. I remember at Feltham, every time I used to go to the main gate, there was an old photograph of the Borstal and all these guys with the big moustaches and all these women that scared me, just the photograph! The idea was to bring them in and scare the hell out of them, so they would never commit crime again. And as I said, we had the new wave of prison officers and prison governors who were thinking, 'Hold on a minute, these are actually human beings, maybe they can change'. What I'm trying to explain is the difficulty in accepting what was actually the reality of what was going on. When you are looking at things like abuse in custody, or sexual violence, don't forget that for all the people in there, they'll have the same internal challenges in accepting what is really going on and finding a way to deal with it.

Tilt: I think John [Podmore] is right about pointing to the fact that prison staff and prison officers are going to be a reflection of the community. They come from the wider community and are going to bring those attitudes. But I do think that there is a responsibility on the prison service, given the service that's being provided and the nature of the coercive role between staff and prisoners, there is a responsibility to try and take them beyond that, to increase their understanding. The difficulty has always been (and I'm not up to date these days), but on the

whole training prison officers has been going backwards in terms of the amount that is available. There is a very good case for much, much better training.

Kelmanson: My ire is directed not at individual prison officers, but at the system.

Tilt: I agree.

Podmore: I don't want to get nostalgic about what it used to be, but Richard as governor of Gartree will remember when I came in and joined the system that we had reviews for lifers. I was the lifer governor in Maidstone and each year we had to write a lifer report. To write that report I would chair and the governing governor would be there and I'd be his scribe, and around the table would be a psychologist, a medical officer, someone from the works department, from education, a whole variety of people and we'd discuss the prisoner. The prisoner would come in, and that would happen every year for a lifer who had reached a certain part in their sentence. That was good learning for us all, not least prison officers who were encouraged to come. Now, I don't know where the parole board is at, but I suspect one of the problems with the parole board at the moment is that it's not getting very much information. I mean I like to think that those reports were quite good quality assessments by everyone and everybody who was working in the prison. I suspect now that the parole board is getting not a lot, and a consequence of that is a parole board that is quite rightly risk averse and not making positive decisions.

Trace: I wanted to introduce something on the back of that discussion about the institutionalisation of the officers. I think there's another dimension to 'out of sight out of mind'. We came into this thinking about sexual violence, but I think it applies to many behaviours inside prison and I think it's as true now as it was in the 1980s. Primarily, prison management is an operational management issue. You've got a set of things to achieve during the day, to make sure nothing goes wrong, to get the food done, get the exercise done. So there is a strong culture from wing officers to governors and beyond to say, 'Well, we need to get the day job done first'. So for things that aren't immediately presenting as an issue to be sorted today, there is no great incentive to say 'Let's go and find out more about it'. I would put sexual violence in that category, as there's no institutional incentive to say 'Let's go and

find new problems to solve', because you've got plenty to be dealing with day in and day out anyway.

Tilt: On the back of that, a different reflection I suppose, which is that I always thought the prison service used the business of having to get through the day as a way of avoiding some of the more difficult problems. And it's not justified, really.

Pertica: If I remember rightly the plaque outside on the [prison] wall says that we are here to protect the community from those sent from the courts and to rehabilitate them to lead a crime-free life upon release. But you've got the revolving door and the appalling level of recidivism, because rather than using the period in incarceration for a rehabilitative process as well as feeding them and getting them to walk in the yard, particularly in relation to problematic drug users, they keep coming back over and over again. It is not good for the individuals, and it's also not good for the prison service, because we could probably reduce the prison population I would imagine by a fifth if we could do better.

Kelmanson: In my day, pre-NAT, the prison population was about 50,000, in 1980 or 1983.

Tilt: At the beginning of the 90s it was 40,000.

Kelmanson: There you go. I was going to ask, when did Michael Howard become Home Secretary – when did he do it? I was just wondering how long it's taken.

Tilt: 1994 until about 97.

Kelmanson: And have we recovered yet?

Pertica: It depends who you ask!

Piper: I think that, and it's still the case, sociologically you need to look at the views of the public on the institutions that are prisons and the people within them. It is another difficult factor. For politicians, prisons don't have votes in them, it doesn't win them votes. The budget

has to come via the politicians so it's very like the NHS, but I always used to say it's so completely different, the health service. I came in from the health service to the prison service, and the difference in funding was unbelievable. There was no comparison. People were having to do very difficult things in a very difficult environment. And again I'd go back to saying what I said before, that there were some very remarkable people who were trying hard despite the odds.

Podmore: I talked about my cultural learning with Addaction. I think, and Mike and I have had this conversation, that within the drug treatment world and rehabs, there's a whole culture there which the prison service hasn't really taken the opportunity to embrace. At the height of working with Addaction at Swaleside I had a wing of 120 prisoners run by one officer and a drug worker. It was self-policing: they would say 'I think you need to test today because someone has brought some stuff in'. You remember the days of SWIP [Shared Working in Prisons],<sup>54</sup> and we almost got there with probation officers and prison officers working together on wings and collaborating, and then we kind of let that one go as well. I think it's a great shame. Where we are at now, you can see it in the figures. If we are talking about drugs, and we are talking about some of the failings, I think there were some opportunities missed in terms of how we could have been running prisons better, in a collaborative way.

Pertica: Perhaps a study that looks at such a long period could also identify this. We don't seem to learn from the past. When I got my management qualification, they said to me, 'Paolo, very rarely are you going to be dealing with something in a role as a manager that somebody else has not dealt with before'. I was listening to Ruth and I think it's diabolical that here is an individual that's got probably the most comprehensive experiences in the country about prison life and what works in prison, and the ministers don't think to ask Ruth. To me, I just can't comprehend that. If you've got an individual around the table with half a century of experience, why would you not say 'Right, please tell me what you think is best to do'.

Kelmanson: What was the Woolf thing?

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<sup>54</sup> Shared Working in Prisons aimed to facilitate multi-disciplinary approaches, involving prison officers, probation officers, and psychologists. It was implemented in some prisons in the mid-1990s. It may have had roots in an earlier programme, Social Work in Prisons, which ran in various forms from 1977 to 1986.

Runciman: That was Strangeways.<sup>55</sup>

Kelmanson: Did he not recommend something about not moving people every ten minutes?

Tilt: It's very significant. The white paper that followed the Woolf Report it was a very good piece of work. To be fair, the prison service implemented almost all of his recommendations. They were unable to implement that. The one major recommendation that he made that was never implemented, despite hours and hours of trying to get it done, was that there should be no overcrowding and that there should be a finite limit set on the number of prisoners that the prison services are required to take, which would in itself would have contributed to the business of slowing down the moving of people and allowing for them to stay much closer to home.

Kelmanson: Also to do with staffing. I gave evidence and I vaguely remember it and one of the points we were making was the fact that prison governor grades moved every ten minutes.

Tilt: Oh, that too.

Kelmanson: That business which meant you couldn't stay for long enough to apply what you learnt!

Trace: Some of the things we were saying in those committees at that time about staffing ratios, about the ability to run rehabilitative regimes, we were saying that in the context of a population of 40,000 or 50,000, and by today's standards, very generous staffing ratios. All of that, including the Woolf enquiry, and the concept of what was an acceptable level of resources and prisoners, has been lost.

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<sup>55</sup> Following the Strangeways prison riot in April 1990, Lord Woolf was appointed to conduct an inquiry. His subsequent report is widely credited as a major influence in prompting prison reform. *Prison Disturbances April 1990: Report of an Inquiry by the Rt. Hon Lord Justice Woolf and His Honour Judge Stephen Tumin* (London: HMSO, 1991).

Kelmanson: When was it?

Tilt: 1992 I think was the white paper. It makes interesting reading to compare that white paper with the one that's been published in the last few months, which I regard as a largely vacuous document. Really, it's a disgrace.

Podmore: It was described as the biggest reform of prisons in living memory, the one that was out this year.

Runciman: On a rather different note I found myself, when doing my homework for today, thinking how impossible it would have been to imagine PrEP, and the whole issue that now HIV can be prevented. The National AIDS Trust sought a judicial review over PrEP.<sup>56</sup> I found myself wondering whether one would reverse harm reduction and say drug misuse is now a greater danger than HIV, but also whether – and this ought to be closely followed – whether PrEP will be available to prisoners. You don't think so?

Piper: Well it should, because it's the NHS, but I think it will be very interesting to see exactly what happens.

Runciman: I think it should be watched very carefully, because after all, the NHS wanted PrEP to be the responsibility of the local authority which is where NAT won this very important judicial review. It's a very important issue and one we ought to remember about.

Berridge: We've gone past the time we said we were going to finish. I know that some people may have other appointments. Before we draw things to a close, is there anything else that has come to mind that anyone would like to talk about before we close? One of the things we talked about very quickly at the beginning was VIR and people have memories of that, but we didn't hear too much about that. I don't know if anyone is wanting to say anything about that, or anything else?

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<sup>56</sup> In 2016, the Court of Appeal ruled in favour of the National AIDS Trust, that NHS England is obliged to give due consideration to commissioning the HIV prevention drug PrEP.

Podmore: Well, just repeating my reflection that I joined when it was around, but it seemed to fairly quickly go. There was just a general thinking that this just isn't reasonable and I think ordinary humanity worked that one out, and I don't recall it being around for very long. We weren't very good at saying 'Why are we doing this?' but I think that was something where we did fairly on say 'This is a bit silly', and it drifted out.

Tilt: A very tiny point I'd like to reinforce is what was said earlier about Robert Armstrong, who was extraordinarily helpful to the prison service even after he retired.

Berridge: Thank you very much indeed; thanks to all of you for coming along and taking part.

## APPENDIX 1: TIMELINE

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### 1981

- July:** The first mainstream press coverage of a new disease, in the *New York Times*.  
**December:** *The Lancet* issues its first report on the new disease, and proposes the name 'gay compromise syndrome'.

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### 1982

- January:** The Centre for Disease Control and Prevention (CDC) in the US publishes its initial surveillance results, noting infected drug users.  
**July:** Death of Terence Higgins, prompting the foundation of a Trust in his name.  
**September:** The CDC uses the term AIDS for the first time.

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### 1983

- The agent responsible for AIDS is discovered in France, and named the lymphadenopathy associated virus.  
**April:** BBC Horizon airs a programme about AIDS in the US, *The Killer in the Village*.  
**May:** St Mary's Hospital in London receives its first patient with AIDS.  
**May:** The Lesbian & Gay Switchboard hosts the first conference on AIDS.  
**October:** The Medical Research Council sets up an AIDS Working Party.

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### 1984

- The agent responsible for AIDS is also discovered in the US, and named HTLV-III. An internationally agreed name is settled upon: the human immunodeficiency virus, or HIV.  
Early tests for the virus are developed in the UK and abroad.  
Amsterdam launches a needle exchange programme for drug users in response to HIV and AIDS.

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### 1985

- January:** An Expert Advisory Group on AIDS set up by the government.  
**February:** News breaks that Rev. Greg Richards, prison chaplain at Chelmsford, has died of an AIDS-related illness. He is the 52<sup>nd</sup> person to die of AIDS in the UK.  
All movement in and out of the prison is briefly suspended.  
HMPS issues guidance to prison staff on how to recognise and respond to AIDS, including reference to the use of Viral Infectivity Regulations.  
**October:** Further guidance is issued to prisons on medical confidentiality, emphasising a 'need to know' policy.  
The UK government awards the first licences for HIV tests.

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## 1986

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The World Health Organisation establishes a Global Program on AIDS.

HMPS's AIDS Advisory Committee is established.

The McClelland Committee publishes its report on HIV infection in Scotland, concluding that the prevention of the spread of HIV should be prioritised over the prevention of drug misuse.

**March:** The Department of Health and Social Services launches the first publicity campaign, 'Don't Aid AIDS'

**November:** The Cabinet Committee on AIDS is set up.

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## 1987

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A training package on HIV/AIDS for prison staff is launched, including the video *AIDS Inside*.

The Health Information Trust publishes a leaflet, 'AIDS: Information for people in prison'.

The UK government launches its AIDS advertising campaign, 'Don't Die of Ignorance', via television and leaflets delivered to every home.

**January:** AZT is approved for use in the US.

**March:** AZT is approved for use in the UK.

**April:** Twelve pilot needle exchange programmes are launched in the UK.

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## 1988

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The Advisory Council on the Misuse of Drugs publishes its first report on HIV and AIDS. This states that AIDS poses a greater risk to individual and public health than drug misuse.

The government refuses permission for research into sex and drugs in prisons, prompting protests outside Pentonville.

The Prison Reform Trust publishes a survey of HIV, AIDS, and prisons in the UK.

**June:** The Council of Europe passes its Recommendation 1080 on AIDS in prisons, including recommendations that prisoners with HIV or AIDS should not be segregated and that prisons should provide condoms and, 'in the last resort', clean needles.

**December:** The first World AIDS Day takes place.

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## 1989

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The ACMD publishes its second report on HIV/AIDS and drugs misuse.

HMPS launches an education package for prisoners, 'AIDS Inside and Out'.

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## 1990

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**April:** Riots in Strangeways prison, Manchester, lasting 25 days.

**July:** An efficiency scrutiny of the Prison Medical Service reports its recommendations, including closer working with the NHS, greater emphasis on health promotion, and the buying in of health care rather than direct provision.

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## 1991

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**January:** The Prison Reform Trust publishes a follow-up to its 1988 report on HIV/AIDS in prisons. It characterises HMPS policy as ‘incoherent and confused’.

**July:** A new Criminal Justice Act comes in to force. This tries to divert drug users out of prisons, and is widely credited with reducing the prison population for a few years.

**July:** Lord Justice Woolf publishes his report on the Strangeways riot. It is wide-ranging in scope, and describes the conditions for segregated prisoners with HIV in Wandsworth as a ‘travesty of justice’.

**November:** HMPS issues revised policy on HIV/AIDS and publishes a working manual, *AIDS and HIV infection: a multidisciplinary approach*.

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## 1992

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HMPS The Wolds opens, the first private prison in England & Wales. It commissions healthcare from a private provider.

**January:** The Prison Advisory Committee on AIDS is reconvened.

**May:** Following the recommendations of the efficiency scrutiny, the Prison Medical Service becomes the Healthcare Service for Prisons.

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## 1993

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**May:** Michael Howard becomes Home Secretary.

An outbreak of hepatitis B and HIV is identified in Glenochil prison in Scotland, and traced to needle-sharing there. The Scottish prison service immediately begins to issue disinfecting tablets and educational materials to prisoners.

**October:** At the Conservative Party Conference, Michael Howard gives a widely reported speech stating that ‘prison works’.

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## 1994

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A new prison drug strategy, including mandatory drug testing, is announced.

The office of Prisons Ombudsman is created.

**March:** The Terence Higgins Trust makes its two prison liaison workers redundant, highlighting that there are now 130 agencies working in prisons.

**May:** Dr Rosemary Wool writes to prison doctors following a confirmed case of HIV transmission between prisoners in England & Wales, to advise that they should prescribe in the best interests of their patients’ health.

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## 1995

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**June:** The recommendations of the Prison Advisory Committee on AIDS are published. These include the provision of disinfecting agents and condoms. All recommendations are accepted except one: the provision of condoms.

Disinfecting tablets are briefly introduced in prisons and withdrawn amidst safety concerns.

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## 1995

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**August:** Dr Wool writes again to prison doctors on the subject of HIV and condoms. She confirms explicitly that they are able to prescribe condoms.

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## 1996

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The ACMD follow-up report, *Drug Misusers and the Criminal Justice System*, is published.

**March:** Highly active antiretroviral therapy (HAART) is approved for use in the US.

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## 1998

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HMPS reintroduces disinfecting tablets in 11 prisons, as a pilot study.

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## 1999

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New prison health units are established within the Department of Health.

The evaluation of the disinfecting tablet pilot programme is published, and recommends a rollout across the prison estate.

**January:** Death of Judith McGlinchey, a Holloway prisoner undergoing detoxification.

**July:** The High Court hears a case brought by a gay prisoner, Glen Fielding, challenging HMPS policy on condoms. It finds that the policy is lawful.

**APPENDIX 2: STILLS FROM 1987 TV CAMPAIGN 'DON'T DIE OF IGNORANCE'**  
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## BIOGRAPHICAL NOTES

### **Professor Virginia Berridge, PhD FRHistS FAcSS Hon FFPH Hon FRCP**

Professor of History at the London School of Hygiene & Tropical Medicine; joined LSHTM in 1988 as Co-Director of the AIDS Social History Programme; author of *AIDS in the UK: The Making of Policy* (1996), *Demons: Our Changing Attitudes to Alcohol, Tobacco, and Drugs* (2013), *Public Health: A Very Short Introduction* (2016).

### **John Dring OBE**

Joined HMPS in 1970 as an Assistant Governor at Strangeways; subsequently at Wellingborough Borstal, HMPs Leicester, Featherstone, and Aylesbury, with periods spent training new recruits and as a staff inspector. Head of staff training in the early 1990s, and Area Manager for the Thames valley and surrounding region from 1996. Retired in the early 2000s, becoming a Trustee for the Prison Advice and Care Trust (Pact).

### **Andrea Kelmanson**

National AIDS Trust Deputy Director from its formation in 1988 until 1992 and convenor of the AIDS & Prisons Forum; adviser to the HMPS AIDS Working Group during that time. Subsequently CEO of the National Centre for Volunteering, and from 1997 a consultant specialising in 'rescue and renewal' work with troubled charities.

### **Jan Palmer**

A community substance misuse practitioner with the NHS in outer London, recruited to set up the first detoxification unit at HMP Holloway in 1997, then Nurse Consultant in substance misuse for women's prisons and finally Clinical Substance Misuse Lead for Offender Health until 2012.

### **Paolo Pertica**

Remand Drug Worker and then Prison Resource Service Manager and Area Manager at Cranstoun Drug Services, 1992-2001; then went on to take up the post of Drug Action Team Coordinator in Blackpool, then managed the Blackpool Community Safety and Drugs Partnership before becoming Head of Neighbourhood Services then Head of Visitor Services for Blackpool Council.

### **Hilary Pickles PhD MB BChir FRCP FFPH**

Trained as a physician and clinical pharmacologist and spent 14 years in the Department of Health, including two years with the AIDS Unit from 1986. Then 12 years as a district Director of Public Health, interspersed with a year as Director of public health policy at the Public Health Laboratory Service, before retirement in 2008.

### **Dr Mary Piper OBE MB MSc FRCP MFPHM**

Public Health Advisor for HMPS from 1992, then Senior Public Health Adviser for Offender Health from 2000 until retirement in 2014.

### **John Podmore**

Joined HMPS in 1985 and was Governor of Belmarsh, Swaleside and Brixton prisons, an inspector of prisons, and finally at HMPS headquarters in various roles including Head of the Anti-Corruption Unit before leaving HMPS in 2011. Author of *Out of Sight, Out of Mind: Why Britain's Prisons are Failing* (2012); freelance criminal justice consultant, honorary professor of Applied Social Sciences at the University of Durham, and Trustee of the Pilgrim Trust and the Longford Trust.

**Dame Ruth Runciman DBE**

Member of the Advisory Council on the Misuse of Drugs from 1974 to 1995 and Chair of its AIDS & Drugs Misuse Working Group; founding trustee of the Prison Reform Trust, and responsible for the creation of a Citizens Advice Bureau in HMP Wormwood Scrubs, the first of its kind; Chair of the National AIDS Trust from 2000 to 2006, and Chair of the UK Drugs Policy Commission from 2001 to 2013.

**Sir Richard Tilt**

Joined HMPS as an Assistant Governor in 1966 and was Governor at HMP Gartree and Bedford, amongst others, before appointment as Director General in 1995. After retirement in 1999, chair of the Social Security Advisory Committee for some seven years, and currently chair of the Internet Watch Foundation.

**Mike Trace**

Head of the Criminal Justice Service at Cranstoun Drug Services from 1987, developing the Parole Release Scheme, then UK government Deputy Anti-Drugs Co-ordinator until 2001; now Chief Executive at RAPt.

**Janet Weston**

Research Fellow at the Centre for History in Public Health, London School of Hygiene & Tropical Medicine; author of *Medicine, Sexual Crime and the Penal System in England 1919-1960s* and various articles on crime, punishment, medicine, and HIV/AIDS.