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COUNTERBLAST: New Work Opportunities for Prisoners: Farmer's Lung, Fettler's Wrist, or Baker's Hands

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It was in October 2010 when Justice Secretary, Ken Clarke, announced at the Conservative Party Conference in Birmingham that he wanted prisoners to move towards working a 40-hour week, and that expanding the capability of prison industries would get such a system going. Mr Clarke's aim was to get prisoners to work full time, at the UK minimum wage, with a proportion of their wages going to their victims. His main motivation, he claimed, was to end the regime of 'sluggishness and boredom' for many prisoners, 'who view getting up in the mornings as being optional'. He was keen on establishing the 'routine of hard work'. This plan received some publicity at the time, but faded from the news very quickly. Mr Clarke had clearly not done his historical homework – the Director of Medical Services for the Prison Commission in 1954, H.K. Snell, had previously expounded the virtues of having prisoners work eight hours a day, only if the social attitudes of what constituted punishment were assessed (Snell 1954). This was in accordance with the Gladstone Committee's view in 1895 that prison should maintain, awaken and stimulate the susceptibilities of prisoners and turn them into better men (see Harding 1988). However, such views were expressed decades before the dawn of the health and safety culture in which we now find ourselves, when the duty of care that prisons had was negligible compared with current times.

That Mr Clarke should announce his plans in a convention centre in the heart of the old industrial quarter in Birmingham, one of the greatest industrial cities in the world, has a weary irony that should provide him with a warning. In the course of its history, Birmingham and its people have manufactured almost everything imaginable, and exported it around the world to great success – from boilers, steam engines and cars, through to guns, medicines and munitions. The price of this success was the shocking level of occupational ill-health problems (or what used to be more

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honestly called 'industrial disease') among the workers of the midlands. The potential for exceptionally high levels of industrial disease among prisoners who may be engaged in this proposed work programme is of concern to me.

The grandfather of occupational medicine was the 17th-Century Italian physician, Bernadino Ramazzini, who made a life's work of studying the links between diseases among the common man and their occupations. He wrote in *De Morbis Artificum Diatriba* in 1713: 'When a doctor arrives to attend some patient of the working class . . . let him condescend to sit down . . . if not on a gilded chair . . . on a three-legged stool. He should question the patient carefully . . . so says Hippocrates. I may venture to add one more question: What occupation does he follow?'. Despite a few hundred years of the medical profession exploring the links between work and ill-health, one thing has remained constant, as summarised by the American satirist, Ogden Nash: 'Those who work standing up do less well than those who work sitting down'. The division between occupational status and industrial disease has remained – with professionals and experts rarely being exposed to dangerous substances, prolonged loud noises, chronic vibrations, fumes, toxins or carcinogens. The more manual and less-skilled the job, the greater the health hazards that are present, and the greater the level of industrial disease that follows.

Mr Clarke does have a good point, of course, in that generally the worst kind of job to have is 'unemployment' and, therefore, working is generally good for the body and mind, as well as for lower reoffending rates, and post-release employment. This is a sentiment echoed by both the Howard League and the Penal Reform Trust; however, the kind of jobs, processes and services that prisons will be able to operate successfully (that is, competitively) will likely be the ones that come with the greatest health and safety risks. Given the level of education and ability among the prison population, and the enforced minimum wages that are planned, then the race for the bottom will be on. Prisons will risk becoming a magnet for providing the dirty, outsourced jobs that people do not want to do because they are risky, and of lower social value. Ancient Egyptians and Chinese used slaves and convicts to do the dangerous jobs, such as mining and mineral extraction – and a return to those days is clearly a retrograde step. This opens up a theoretical and humanistic argument at the core of my concerns; in essence, no person's health should be worse at the end of a day's work than it was at the beginning, whether or not they are a prisoner (Jackson 2010). If someone's health is impacted upon by their work, then something is fundamentally wrong with that process. Another question concerns how prisons will provide effective pre-employment screening – to make sure that prisoners with health problems or disabilities will not be unduly affected by their work.

And if something is, indeed, wrong with the process of mass prison working – then someone will usually be found to be culpable, and under the Health and Safety at Work Act 1974 and the Management Regulations (2002), the potential for the prison service to be under siege from persistent litigation on behalf of prisoners suffering from work-related

ill-health will be huge. One complication of industrial disease is that it is often a slow and insidious process, and health effects can be silent and insidious, such as carpal tunnel syndrome or cumulative trauma disorders among computer keyboard operators. Damage is often being done in the workplace before the worker becomes aware of it, and in the case of respiratory problems, such as silicosis or pneumonoconosis, the time lag between exposure and observable health effects can be worryingly long. This means that prisons will need to be prepared to risk assess almost every single process involved in their prisoner working programmes, as well as complying with very complicated, and potentially expensive, regulations. Health and safety consultants may be the real winners of Mr Clarke's proposed reforms. The occupational health of prisoners cannot be ignored if the prison working population, and the variety of jobs it undertakes, is set to expand – and although providing occupational health to prison workers will no doubt cost money, it will be a fraction of the costs that will ensue if prisoners are to be made ill by the work they do.

The alternative may be for the prison service to restrict its work programme to the 'clean' jobs that can be performed safely and securely by prisoners, without much risk to their health. In India for instance, prisoners are already used as employees in call-centre operations – and although these appear to be clean and healthy jobs, current research into the well-being of call-centre workers suggests that the prisoners' chances may be better if they opted to go back down the mines!

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