



LJMU Research Online

Sim, J

Aching desolation: Liverpool prison and the regressive limits of penal reform in England and Wales

<http://researchonline.ljmu.ac.uk/id/eprint/10716/>

Article

Citation (please note it is advisable to refer to the publisher's version if you intend to cite from this work)

Sim, J (2019) Aching desolation: Liverpool prison and the regressive limits of penal reform in England and Wales. *Critical and Radical Social Work*, 7 (1). pp. 41-58. ISSN 2049-8608

LJMU has developed **LJMU Research Online** for users to access the research output of the University more effectively. Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in LJMU Research Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain.

The version presented here may differ from the published version or from the version of the record. Please see the repository URL above for details on accessing the published version and note that access may require a subscription.

For more information please contact researchonline@ljmu.ac.uk

<http://researchonline.ljmu.ac.uk/>

article

Aching desolation: Liverpool prison and the regressive limits of penal reform in England and Wales

Joe Sim, j.sim@ljmu.ac.uk
Liverpool John Moores University, UK

This article explores the current penal crisis through a case study of Liverpool prison, and the appalling nature of the prison's regime, as documented in January 2018 by HM Inspectorate of Prisons. The dehumanising nature of the regime was not unique as a number of other prisons inspected during 2018 were also shown to be seriously detrimental to the health and safety of prisoners. The article also explores the problematic nature of the state's response to the crisis and the limitations of that response. This raises a number of theoretical and political questions about the abject failure over two centuries of liberal reform. In turn, this failure raises questions about the future, beginning with recognising that the prison should be understood as an institution of the neoliberal state, which is oriented towards criminalising and controlling those on the economic and political margins of a deeply divided, fractured social order.

key words Liverpool prison • crisis • reform • resistance • abolitionism

To cite this article: Sim, J. (2019) Aching desolation: Liverpool prison and the regressive limits of penal reform in England and Wales, *Critical and Radical Social Work*, DOI: 10.1332/204986019X15491042559709

Introduction

This article focuses on three issues.¹ First, it critically analyses the searing report on HM Prison Liverpool, which was inspected by the Prison Inspectorate in September 2017. The report was published in January 2018 (HM Chief Inspector of Prisons, 2018a). The data generated from this, and other reports produced by the Inspectorate, provide the basis for the development of this article's critical argument. Second, it considers the state's response to the report and explores how a regressive network of political and cultural power, operating in moral entrepreneurial terms through the mass media, framed the popular understanding of the Liverpool report, and the crisis in prisons more generally. Finally, the article considers what should be done. It contends that the response to the current penal crisis lies not in the politics of liberal reform, but in developing an abolitionist analysis and strategy to fundamentally transform prisons. In developing this argument, the article builds on the radical critiques of the prison system in England and Wales from academics (Sim, 2009; Scott, 2018)

1 and activist groups and charities such as Women in Prison and INQUEST. Taken
 2 together, these interventions have not only highlighted the state's abject failure to
 3 protect prisoners, but have also illustrated the failure of the traditional prison reform
 4 lobby, and their academic supporters, to move beyond the snake oil discourse of
 5 crisis–reform–crisis–reform that has dominated their praxis for the last two centuries
 6 but that has done little, if anything, to develop a system of detention, for the few
 7 individuals who need to be confined, that is just, humane and accountable.

9 **HM Prison Liverpool: harming the confined**

10
 11 Until August 2018, when it was superseded by HM Prison Birmingham, the
 12 report on Liverpool was the worst that the Inspectorate had published since it was
 13 formed in 1981. Its scathing conclusions about the dire state of the prison generated
 14 an unprecedented response from the state. Prison managers and ministers were
 15 summoned to appear before the House of Commons Justice Committee to discuss
 16 the Inspectorate's findings (Sim, 2018a).

17 The prison failed the four tests that inspectors used to judge the health of individual
 18 prisons: safety, respect, purposeful activity and rehabilitation and release planning. In
 19 stark detail, the report meticulously highlighted the institution's 'abject failure ... to
 20 offer a safe, decent and purposeful environment' to prisoners (HM Chief Inspector of
 21 Prisons, 2018a: 5). It illustrated the brutal impact of the regime's systemic, corrosive
 22 failings on the physical, psychological and emotional well-being of the prisoners.
 23 The 'squalid' living conditions that many prisoners 'endured' were central to the
 24 Inspectorate's concerns:

25
 26 Some [cells] had emergency call bells that were not working but were
 27 nevertheless still occupied, presenting an obvious danger to prisoners.
 28 There were hundreds of unrepaired broken windows, with jagged glass left
 29 in the frames. Many lavatories were filthy, blocked or leaking. There were
 30 infestations of cockroaches in some areas, broken furniture, graffiti, damp
 31 and dirt.... The prison was generally untidy and in many places there were
 32 piles of rubbish that had clearly been there for a long time, and in which
 33 inspectors reported seeing rats on a regular basis. (HM Chief Inspector of
 34 Prisons, 2018a: 5)

35
 36 One prisoner with complex mental health issues was:

37
 38 held in a cell that had no furniture other than a bed. The windows of both the
 39 cell and the toilet recess were broken, the light fitting in his toilet was broken
 40 with wires exposed, the lavatory was filthy and appeared to be blocked, his
 41 sink was leaking and the cell was dark and damp. Extraordinarily, this man
 42 had apparently been held in this condition for some weeks. The inspectors
 43 had brought this prisoner's circumstances to the attention of the prison, and
 44 it should not have needed my personal intervention for this man to be moved
 45 from such appalling conditions. (HM Chief Inspector of Prisons, 2018a: 5)

46
 47 The private company Amey had been contracted to maintain the prison.² However,
 48 2,000 jobs were outstanding at the time of the inspection, contributing further to

1 the demoralising nature and impact of the regime (HM Chief Inspector of Prisons,
2 2018a: 15). Prisoners endured these gruelling conditions for the majority of their
3 sentences as there was little or no purposeful activity. Of those surveyed, 43% told
4 the Inspectorate that they spent less than two hours out of their cells on weekdays,
5 there were no association periods and exercise lasted for 30 minutes (HM Chief
6 Inspector of Prisons, 2018a: 43).

7 8 *Failing health and safety* 9

10 Between May 2015 and September 2017, the date of the Inspectorate's visit, four
11 prisoners took their own lives. There were another two suspected self-inflicted deaths
12 after this inspection. Liverpool had an ignominious history of such deaths, a point
13 this article returns to later. Incidents of self-harm were increasing. Between March
14 and September 2017, there were 184 such incidents. While the report recognised
15 that individual initiatives were in place to manage risks, 'the overall strategic response
16 to reducing self-harm was underdeveloped' (HM Chief Inspector of Prisons, 2018a:
17 26–7). Over the previous six months, Assessment, Care in Custody and Teamwork
18 (ACCT) forms had been opened on 546 occasions.³ The governance of these
19 prisoners, officially regarded as vulnerable, was problematic, particularly at night:

20
21 an officer on one unit was responsible for making observational entries,
22 on average, once every five minutes during his 11-hour shift.... We were
23 shocked to find that another officer was unaware that he carried a cell key for
24 use during an emergency. The quality of ACCT documents was inadequate:
25 triggers were incorrectly recorded, care maps were incomplete and reviews
26 were late. (HM Chief Inspector of Prisons, 2018a: 27)

27
28 Humane treatment and decent conditions are central to preventing self-inflicted
29 deaths in the early stages of confinement. Despite this knowledge, conditions in
30 the reception area were poor: 'only 16% of prisoners said that their first night cell
31 was clean. The cells that we inspected were austere and shabby but efforts had been
32 made to remove graffiti' (HM Chief Inspector of Prisons, 2018a: 21). In terms of
33 medical care:

34
35 [c]linical rooms varied in cleanliness. Some wing and reception clinical
36 rooms were in a poor state of decoration. They were not cleaned regularly
37 and did not meet required infection control standards.... No information
38 could be provided by the relevant contractor regarding the Legionella risk
39 from a disused bath.... Not all equipment had been tested and maintained.
40 (HM Chief Inspector of Prisons, 2018a: 36)

41
42 Finally, 'the serious lack of capacity ... and failure to allocate sufficient custody staff
43 to the inpatient unit led to unacceptable outcomes for many of the most vulnerable
44 prisoners' (HM Chief Inspector of Prisons, 2018a: 15).

Failing families and failing prison programmes

Despite family contact being regarded by the state as fundamental to the process of rehabilitation, the report noted that '[t]he support given to men to maintain contact with the outside world had deteriorated since the last inspection and opportunities were missed in several areas' (HM Chief Inspector of Prisons, 2018a: 49). Prisoners experienced 'significant delays in adding telephone numbers to their pin phone account' while an astonishing 66% of those surveyed had problems receiving or sending mail (HM Chief Inspector of Prisons, 2018a: 49). Additionally, 'too many prisoners were placed on closed visits for reasons unrelated to visits' (HM Chief Inspector of Prisons, 2018a: 49). Programmes designed, in theory, to rehabilitate prisoners were absent: there was no offender management policy; there was no coordination between the different groups involved in rehabilitation; assessments were poor; and only 23% of prisoners surveyed indicated that they had a custody plan (HM Chief Inspector of Prisons, 2018a: 50–1).

Force and unofficial punishments

In the previous six months, force had been used on 288 occasions (HM Chief Inspector of Prisons, 2018a: 12). However, the prison failed to document its use in any detail. Crucially, 'incomplete' paperwork:

did not provide assurance of proportionate and necessary use.... Some completed records also indicated that excessive force had been used by staff but managers were not aware of this. Monthly use of force meetings were not held routinely and not all use of force incidents were reviewed. (HM Chief Inspector of Prisons, 2018a: 12–13, emphasis added)

Unexplained injuries 'were recorded but not investigated' (HM Chief Inspector of Prisons, 2018a: 25). Prisoners who refused to leave the segregation unit were subjected to sanctions that '*lacked decency* such as withholding showers and telephone calls' (HM Chief Inspector of Prisons, 2018a: 25, emphasis added). The report noted that these sanctions were 'applied by staff outside of any formal policy' and therefore '*constituted unofficial punishment*' (HM Chief Inspector of Prisons, 2018a: 25, emphasis added).

Differential suffering

Compared with their white counterparts, black and minority ethnic prisoners 'spoke more negatively in our groups and individually about their treatment from other prisoners and staff' (HM Chief Inspector of Prisons, 2018a: 33). The monitoring of different systems in the prison – adjudication, incentives and earned privileges and complaints – showed 'a disproportionate number of prisoners in the areas of age, ethnicity and religion' (HM Chief Inspector of Prisons, 2018a: 33). The reasons for this had not been investigated. There was 'little evidence of staff using professional interpreting and translation' for foreign national prisoners (HM Chief Inspector of Prisons, 2018a: 34). Consequently, they were isolated on the prison's wings. In a prison where 450 prisoners had self-identified as being disabled, the institution

1 was 'unable to meet the needs' of many of them while there had been a significant
2 deterioration in mental health provision (HM Chief Inspector of Prisons, 2018a: 39).

3 4 ***A failure of accountability***

5
6 Structures of governance and accountability were effectively non-existent. Prisoners'
7 complaints were not addressed or taken seriously. Only 10% of those surveyed, who
8 had made a complaint, said that it had been dealt with within seven days. Additionally,
9 only 20% felt that complaints were dealt with fairly. The inspectors found 'a number
10 of responses to complaints in a wing office *which had been there for as long as three months*
11 *without being returned to prisoners...* Quality assurance of complaints was not robust'
12 (HM Chief Inspector of Prisons, 2018a: 31, emphasis added). Legally, prisoners were
13 isolated and bereft. There was 'no legal advice service', no "access to justice" laptops,
14 no information displayed about bodies such as the Legal Ombudsman and legal visits
15 were late in starting. Additionally, there was no system for tracking applications.
16 Only 22% of prisoners said that their applications were dealt with within seven days
17 and no action was taken at meetings (HM Chief Inspector of Prisons, 2018a: 31–2).

18 Prisoners were not only failed individually in terms of the lack of accountability
19 in dealing with their complaints. At an institutional level, recommendations from
20 previous inspections, designed to improve the regime, had effectively been ignored,
21 a situation not unique to Liverpool. Of the 89 recommendations made in 2015, only
22 23 had been achieved, 14 had been partially achieved and 53 had not been achieved
23 (HM Chief Inspector of Prisons, 2018a: 11).⁴ In the key area of safety, only three
24 out of 15 recommendations had been achieved, two had been partially achieved and
25 10 had not been achieved (HM Chief Inspector of Prisons, 2018a: 12).

26 Internally, while there were some examples of good practice, in reality, at every
27 level, Liverpool was a failing prison. This was compounded by local, regional and
28 national prison managers who ignored the devastating impact of the regime on
29 prisoners' lives. This failure in governance did not prevent senior prison managers
30 from receiving large salaries and bonuses. In 2016/17, the Chief Executive of the
31 Prison Service earned between £145,000 and £150,000. An additional £25,000
32 was paid into his pension scheme while he, and four other senior managers, shared
33 between £50,000 and £75,000 in bonuses (Sim, 2018a). How did the state respond
34 to the Inspectorate's devastating indictment of the prison?

35 36 **The state's response: 'philosophis[ing] disgrace'⁵**

37
38 Following the report's publication, the House of Commons Justice Select Committee
39 met for three hours. This was unprecedented. It was the first time that the Committee
40 had considered a report on an individual prison 'because, frankly, we were so horrified
41 at what we saw' (House of Commons, 2018).

42 The Committee heard from six witnesses, including Rory Stewart, the newly
43 appointed Minister of State. He was the fifth prisons minister since 2010. Over the
44 same period, there had been seven Ministers of Justice. Members were told that
45 a number of the worst cells had been removed and that purposeful activity had
46 increased. Importantly, they acknowledged that '*staffing was not an issue, because the*
47 *staff were up to a high level*' (House of Commons, 2018: emphasis added). Therefore,
48 staffing levels did not explain the degrading state of the prison and the complacent,

1 dismissive attitudes displayed by prison staff towards prisoners. This directly challenged
2 the relentless line pursued by the Prison Officers Association (POA) concerning
3 the negative impact of budget cuts on staff, a point the article returns to later. The
4 Committee also highlighted the non-implementation of official recommendations.
5 Between 2013/14 and 2017/18, the number achieved declined from the already low
6 figure of 46% to 37% (House of Commons, 2018).⁶

7 Despite its unprecedented intervention, the Committee's response was limited.
8 Key issues identified by the Inspectorate, such as the official and unofficial infliction
9 of punishment, were ignored. Its deliberations were overwhelmingly concerned
10 with the conditions and the management of the prison. While pushing these issues
11 into political and popular consciousness was important, the Committee ignored
12 the power exercised at every level of the prison, principally through the fierce
13 and unforgiving occupational culture of the staff and the powerlessness, fear and
14 terror that this induced in the prisoners. This culture, and its lack of accountability,
15 continued to be the elephant in the penal corner. Despite being an exceptionally
16 visible, desperately imposing presence, there was a proverbial wall of silence around
17 it, a refusal to recognise, and face up to, its deleterious impact on an often-fragile
18 and frightened population.

19 In February 2018, in a letter to the Committee, Rory Stewart followed a similar
20 trajectory in closing down the debate about the abject state of the prison, the lack
21 of accountability and the insidious role of prison staff in dehumanising prisoners. So,
22 while he discussed improving standards and 'boosting ... education and employment
23 prospects', his 'immediate focus' was to look 'very closely at what can be done to
24 drive down the use of illicit substances behind bars' (Ministry of Justice, 2018a: 1–2).
25 Not for the first time, the spectre of the drug-addled prisoner was central to the
26 state's narrative and structured the political and popular debate about the crisis in the
27 prison and what should be done about it.

28 29 **Distraction, disavowal and denial**

30 The Committee's limited response to the Liverpool report was reflected in the official
31 response to the wider prison crisis that had erupted in November 2017. The combined
32 political and cultural weight of politicians, the POA, the prison reform lobby and
33 the majority of media commentators reduced the complexities of the crisis to often-
34 superficial sound bites. Five interrelated themes were involved in operationalising
35 this ideological process of distraction, denial and disavowal.

36 First, this process was based on an ahistorical reading of penal policy. The crisis
37 in 2017 was the latest in a line of often-profound ruptures that had gripped the
38 institution since its emergence in the late 18th century. These crises had generated a
39 self-referential, self-defeating cycle of crisis–reform–crisis–reform based on a liberal
40 discourse which endlessly claimed that the prison could redeem itself through finding
41 the golden fleece of reform, which, in turn, would provide the key to rehabilitating
42 prisoners (Fitzgerald and Sim, 1982). For Foucault:

43
44
45 word for word, from one century to the other, the same fundamental
46 propositions are repeated.... So successful has the prison been that, after
47 a century and half of 'failures', the prison still exists, producing the same
48

1 results and there is the greatest reluctance to dispense with it. (Cited in Sim, 2009:
2 7, emphasis added)

3
4 Second, the POA, in particular, was vociferous in framing the crisis in the context
5 of staffing cuts. Restoring the prison budget to its pre-cuts level would, the POA
6 argued, alleviate the crisis and re-establish the penal and, in their view, benevolent
7 status quo. However, this position conveniently and consciously ignored a key point:
8 the pre-cuts prison was also a site of terror and trauma for prisoners, and was a space
9 and place of death. Between 1990 and 2010, *before* the cuts began, there were nearly
10 2,500 deaths in prison, 1,404 of them self-inflicted (data computed from inquest.
11 org.uk, cited in Sim, 2017).

12 In the pre-cuts era, self-inflicted deaths had also been a feature of the Liverpool
13 regime. Between 1990 and 1996, 20 prisoners killed themselves. Furthermore, while
14 prison managers claimed that staff had 'introduced a number of measures in a bid
15 to reduce suicides' (Campbell, 1997: 5), in January 2011, the Prisons and Probation
16 Ombudsman (PPO) highlighted another death, the 16th in the prison since April
17 2004. The PPO concluded that staff could not have 'reasonably foreseen or prevented
18 [the prisoner] from taking the apparent action that he did' (Prisons and Probation
19 Ombudsman, 2011: 14–15). However, there was an issue about observing and
20 recording any changes in the behaviour of prisoners in their care. The Ombudsman
21 made 'no formal recommendation' but asked 'the Governor to satisfy himself that all
22 staff who have contact with prisoners have received ACCT training to foundation
23 level' (Prisons and Probation Ombudsman, 2011: 14–15). Between January 2012
24 and December 2017, 31 prisoners died in the prison; 14 of these deaths were self-
25 inflicted, while two were awaiting classification (INQUEST, 2018a). In October
26 2018, there were a further three deaths in the space of four weeks (*Liverpool Echo*,
27 2018). The trauma experienced by prisoners was encapsulated by Tony Paine, who
28 killed himself in February 2018. In a poignant letter to his mother and 'desperate
29 beyond emotion',⁷ he described how he had been 'nearly stabbed twice in a week.
30 Am in a bad way. I've cut my arms. They won't move me unless I grass. Help me
31 please' (cited in Thomas, 2018: 4). Establishing a binary divide between the pre- and
32 post-cuts prison ignored this longer history of death and confused cause and effect.
33 The cuts intensified already deadly regimes established over two centuries; they did
34 not cause self-inflicted deaths as the dominant narrative contended (Sim, 2017).

35 Third, according to the POA, the dangers that its members faced had increased as a
36 result of the cuts. The POA was remorseless in pushing this argument. In November
37 2016, it led a series of protests claiming that it had 'consistently raised the volatile
38 and dangerous state of prisons, as chronic staff shortages and impoverished regimes
39 have resulted in staff no longer being safe, a lack of discipline and prisoners taking
40 control of areas' (EurWORK, 2017).

41 In articulating their concerns, prison officers, as state servants, constructed and
42 established the narrow, political, popular and moral parameters within which their
43 safety was understood. The dangers faced by other occupational groups were
44 effectively ignored. The Shirebrook warehouse, run by Sports Direct, provides a
45 compelling example of this issue. Between January 2013 and April 2016, there were
46 110 incidents involving workers that required medical intervention. Of these incidents,
47 50 were classified as 'life-threatening' while 12 were classified as 'major' injuries.
48 Staff were 'three times more likely to be injured at Shirebrook than in agriculture –

1 statistically the most dangerous industry in the UK' (Armstrong, 2017: 91). Five of
 2 the cases involved pregnant women. One woman 'had gone to work despite being
 3 heavily pregnant – afraid of losing her job. After giving birth, she tried to go back
 4 to work. Ambulance staff told the police, who then arrested her for wilful neglect'
 5 (Armstrong, 2017: 92). National Health Service (NHS) personnel are another case
 6 in point. In England, in 2016/17, there were over 56,000 physical assaults on staff,
 7 a rise of nearly 10% on the previous year. Paramedics, nurses and mental health staff
 8 were the most likely to be assaulted (Campbell, 2018). In contrast:

9
 10 Since 1850 only eight members of staff (and not all of these prison officers)
 11 have been killed in prisons in England and Wales. The last prison officer
 12 to be murdered at work was Derek Lambert, who was killed at Portland
 13 borstal by a prisoner in 1965. It was the first murder of a prison officer for
 14 some 30 years in England and Wales and proved to be an isolated incident.
 15 Not only is serious physical violence against officer[s] by prisoners rare, but
 16 there are also many examples of prisoners going to their aid in dangerous
 17 situations, such as during prison disturbances. (Scott, 2016)

18
 19 The discourse of danger is also built on the idea that prison officers are being assaulted
 20 on a daily basis. However, the number of days lost as a result of assaults by prisoners
 21 on staff is minimal when compared with the other health and safety issues they face.
 22 This has a long history. The health of staff is more often compromised by stress,
 23 bullying, sickness, anxiety, depression and musculoskeletal problems than by assaults.
 24 In 1999, the National Audit Office (NAO) pointed out that sickness arising from
 25 accidents and assaults 'represented a small proportion' of absences from work among
 26 prison officers; in the latter case, it was 2% of all absences. The number of days lost as
 27 a result of depression, anxiety, stress and nervous debility rose by 53% from 116,744
 28 days lost in 1999/2000 to 178,625 days lost in 2002/03. In contrast, the number
 29 of days lost as a result of accidents rose from 824 to 1,201 and the number of days
 30 lost as a result of assaults increased from 397 to 693 (cited in Scott and Sim, 2018).

31 Fourth, the narrow discussion of the dangers that staff faced involved a process of
 32 'state talk':

33
 34 States, if the pun be forgiven, *state*; the arcane rituals ... define, in great detail,
 35 acceptable forms and images of social activity and individual and collective
 36 identity; they regulate, in empirically specifiable ways, much – very much
 37 ... of social life. Indeed, in this sense, 'the State' never stops talking ... moral
 38 regulation is coextensive with state formation, and state forms are always
 39 animated and legitimated by a particular moral ethos. (Corrigan and Sayer,
 40 1985: 3–4, emphasis in original)

41
 42 Thinking about the safety of prison (and police) officers in moral terms has profound
 43 political and ideological implications. The murder of a state servant is hugely symbolic.
 44 It signifies a 'torn and desecrated' social order that can only be fixed through the
 45 righteousness of a retributive, authoritarian response. 'State talk' is crucial to this
 46 deeply ideological process (Sim, 2004: 126). Embodying prison officers as perennial
 47 *and* potential victims over-exaggerates and overdramatises the nature and extent of
 48 the violence they face. It socially and symbolically constructs them as consecrated,

1 benevolent guardians of a social order that is perpetually confronted by a callous tide
2 of lawlessness, chaos and disorder. This deeply regressive process distracts attention
3 away from the systemic, routinised violence perpetrated by the state inside and outside
4 of prisons, and the corrosive harms that this violence generates (Sim, 2004: 125–9).

5 The media was pivotal in the often-uncritical dissemination of the POA's 'state
6 talk'. In a sample of 100 articles published in 2016, prison officers were directly and
7 sympathetically quoted in 49 of them: '[v]irtually all accounts which drew upon
8 the words of prison officers/POA, were sympathetic to their plight and often made
9 direct connections to the decline in officer staffing levels and problems confronting
10 prisons today' (Scott, 2018: 142–4).

11 'State talk' dominated *Channel 4 News* on the evening that the Liverpool report
12 was published. While the broadcast highlighted the harrowing experiences of the
13 families of dead prisoners, the POA's representative dragged the discussion, without
14 challenge, onto the terrain of the cuts. The issues highlighted by the Inspectorate were
15 ignored: the use of unofficial punishments within the authoritarian staff culture; the
16 officially sanctioned use of force and violence; the lack of democratic accountability;
17 the systemic dismissal of prisoners and their experiences; and the pre-cuts prison as a
18 place of terror, trauma, punishment and pain. Instead, the dominant narrative – that
19 the cuts were responsible for the deterioration in the regime – structured the debate.
20 It was a narrative articulated in other media outlets as diverse as *The Guardian* and
21 *The Morning Star* (Sim, 2018a).

22 The silence induced by the reverse process – what could be termed as state non-
23 talk – is also important in marginalising the social harms generated by prisons.
24 Deborah Coles and Helen Shaw have pointed out that many of the 45 inquests they
25 investigated, which had taken place after long delays, had 'been unreported, not even
26 deemed worthy of a couple of lines in the local media', despite revealing 'shocking
27 failures in the treatment of vulnerable detainees' (Coles and Shaw, 2015: 10). The
28 narrowing of the debate about prison safety both politically and popularly, and the
29 endless focus on the dangers faced by state servants, can also be contrasted with the
30 lack of consideration given to the levels of self-harm in women's prisons and the
31 failure of the state to provide a duty of care and place of safety for female prisoners.
32 In the year to June 2018, there were 498 incidents of self-harm per 1,000 prisoners
33 in male prisons, a rise of 20% from the previous year. In women's prisons, the rate
34 was 2,366 incidents per 1,000 women, a rise of 24%. More generally, the level of
35 self-harm had reached a record high of 49,565 incidents, representing a yearly increase
36 of 20% (Ministry of Justice, 2018b: 3–4).

37 Finally, the narrow focus on budget cuts denied the role of staff, at all levels, in
38 reproducing the grim environment prevailing in many institutions. David Scott has
39 identified a number of intertwined discourses, deeply embedded in the formal and
40 informal occupational culture of prison staff, that operate to deny prisoners a full
41 sense of what it means to be human: 'denial of responsibility'; 'denial of injury';
42 'denial of victim'; 'condemnation of the condemners'; and 'appeal to higher loyalties'.
43 Taken together, they create 'ghosts in the penal machine' (Scott, 2008: 176–82).
44 They ensure that prisoners only partially *exist* and do not fully *live* as human beings
45 in the physically demoralising and psychologically withering regimes in Liverpool
46 and other institutions.

Systemic dehumanisation

While Liverpool was a prison in ‘profound anomic disarray’ (Streeck, cited in Sim, 2018b: 180), it was not unique. The Chief Inspector’s report on Nottingham revealed similar issues. The prison’s regime was so problematic that he issued his first ever Urgent Notification Notice, meaning that the Secretary of State had to take personal and public responsibility for improving the regime. He argued that the regime was ‘dangerous’ for prisoners. His conclusion was profound: ‘*[m]y fear, which may prove to be unfounded, is that some could face it no longer and took their own lives*’ (HM Inspectorate of Prisons, 2018b: 7, emphasis added). Safety had been assessed as ‘poor’ on three consecutive occasions. The level of self-harm and self-inflicted death was ‘both tragic and appalling’; eight prisoners had killed themselves since the previous inspection in 2016. Again, official recommendations from the Inspectorate and the PPO had been ignored. Only two out of 13 recommendations concerning prison safety had been ‘fully achieved’. Overall, only 12 out of 48 recommendations had been achieved (HM Inspectorate of Prisons, 2018b: 13).⁸

Exeter prison was also indicted for its degrading treatment of prisoners. Crucially, like Liverpool, Exeter was *not* understaffed. The Urgent Notification Notice process was again invoked. In a letter to the Secretary of State for Justice, the Chief Inspector pointed out that:

[in] the context of a prison with significant levels of vulnerability among prisoners, and where suicide and self-harm are at such high levels, it was shocking to see the way in which cell call bells were routinely ignored by staff. Given that the prison is now much better staffed, this was inexcusable. Inspectors saw bells going unanswered even when staff were doing nothing else. Even on the first night and induction landings, where prisoners are likely to be at their most vulnerable, bells were left unanswered for long periods. The prison’s own recording system showed that it was commonplace for bells not to be answered within a reasonable time. The system was either not being reviewed by managers, or what it revealed was being ignored. (HM Inspectorate of Prisons, 2018c: 3)

The inspectors described the harrowing treatment of one vulnerable prisoner who was:

assessed as being at heightened risk of suicide and self-harm, who should have been located on the dedicated first night unit, [but who] was instead placed on C1 wing, a subterranean unit that was in effect being used as a segregation unit but without any of the usual safeguards. This prisoner spent three days on this unit before moving to the first night unit where inspectors saw him in a squalid cell without bedding, a television or glass in his window. None of this had been reported by staff who were required to check on him regularly as part of his care plan. (HM Inspectorate of Prisons, 2018c: 3)

Safety was given the lowest possible grade of ‘poor’. There had been six self-inflicted deaths since the previous inspection, five in 2017 alone. Rates of self-harm were higher than comparable prisons and had also risen by 40% since the previous inspection.

1 The Inspectorate ‘saw many examples of a lack of care for vulnerable prisoners
2 which, given the recent tragic events in the prison, were symptomatic of a lack of
3 empathy and understanding of the factors that contribute to suicide and self-harm’
4 (Sim, 2018c). This lack of sympathy, alongside ‘unacceptably poor’ living conditions,
5 made the regime toxic. As with Liverpool and Nottingham, official recommendations
6 had been effectively ignored: of the 14 concerning safety, only three had been fully
7 achieved (Sim, 2018c).

8 The three prisons were rated as 1 in the *Annual prison performance ratings for 2017/18*,
9 indicating that there was ‘serious concern’ over their ‘overall performance’. A total
10 of 15 institutions – 13% of the prison estate – fell into this category. This was the
11 highest proportion since 2011/12. Altogether, 54 prisons (46%) were judged to be
12 of concern or serious concern (Ministry of Justice, 2018c: 5, 1).

13 Another nadir was reached in August 2018 when the report on Birmingham prison
14 was published. It replaced Liverpool as the worst prison inspected by the Inspectorate
15 since its formation in 1981. Conditions were desperate:

16
17 Communal areas in most wings were filthy. Rubbish had accumulated and
18 had not been removed. There were widespread problems with insects,
19 including cockroaches, as well as rats and other vermin. We saw evidence of
20 bodily fluids left unattended, including blood and vomit. I saw a shower area
21 where there was bloodstained clothing and a pool of blood that apparently
22 had been there for two days next to numerous rat droppings. Many cells
23 were cramped, poorly equipped and had damaged flooring or plasterwork.
24 Most toilets were poorly screened, many were leaking and we saw cells with
25 exposed electrics. (Cited in Sim, 2018d)

26
27 Again, the POA dominated the media debate to the point where on the evening that
28 the report was published, *Channel 4 News*, a supposedly liberal broadcaster, conducted
29 an interview with a serving prison officer. Replying to the presenter’s pointedly
30 leading question – ‘Do you feel safe, do your colleagues feel safe?’ – he claimed that
31 ‘*ex-military personnel working in British prisons said they felt safer in Afghanistan and Iraq*’
32 (cited in Sim, 2018d: emphasis added).

33 The scathing reports on Liverpool, Nottingham, Exeter and Birmingham were
34 important in making visible the invisible, systemic processes of degradation and
35 dehumanisation that prisoners suffered in these institutions. They highlighted the
36 state’s failure both to provide a duty of care to prisoners and to ensure that there
37 was some form of democratic accountability to protect them given that official
38 recommendations were consistently and conspicuously ignored. Like rag dolls,
39 prisoners were cast aside by an authoritarian, indifferent prison officer culture. This
40 culture was sustained by a systemic sense of immunity and impunity that left staff free
41 to continue to reproduce brutal, withering daily regimes, a situation that has been
42 implicitly and explicitly condoned, or simply ignored, for decades by politicians, the
43 mass media and liberal academics.

44 The systemic failings in each prison, and the nature of the official response,
45 crystallised the failure of the state to move beyond the self-referential cycle of
46 crisis–reform–crisis–reform that, as noted earlier, has dominated penal policy for the
47 last two centuries. The reports also illustrated that punishment and pain remained
48 intrinsic to the everyday lives of the prisoners. They were constructed, as they have

1 always been, as less eligible subjects existing, not living, in a neoliberal institution
 2 where the cuts to the prison budget had intensified their status as individuals who
 3 were not worthy of being seen as full human beings as a result of their ascribed
 4 status as prisoners (Sim, 2017). They existed in a spectral ‘wasteland of nobodies’
 5 (Amagoalik, cited in Stevenson, 2014: 121). Given this, how can the current situation
 6 be radically transformed to ensure that prisoners are protected and fundamental change
 7 is promoted? The theoretical, political and strategic issues raised by abolitionism go
 8 some way to answering this question.

10 For abolitionism

11 Building on Thomas Mathiesen’s foundational text published in 1974 (Mathiesen,
 12 1974), British abolitionists have long highlighted the capacity of prisons like Liverpool
 13 for delivering punishment, pain and trauma to the confined while critiquing the
 14 failure of the state’s reformist policies to deal with the crisis in individual prisons
 15 and the more general prison crisis (Sim, 1994, Sim, forthcoming; Scott, 2018).
 16 They have pointed to a range of policies and practices that transgress reformism
 17 and that, if implemented, would radically transform the current system, including:
 18 stopping the prison building programme; closing down prisons; dismantling the
 19 authoritarian, prison officer culture; and demanding that staff at all levels of the state
 20 are democratically accountable (Sim, 2009). Michelle Brown and Judah Schept have
 21 developed the abolitionist critique of the prison further by calling for an ‘abolitionist
 22 praxis’, which would include thinking about the meaning of safety – and, by
 23 definition, protection – in the 21st century:

24
 25
 26 Safety ... is not simply about those who have harmed or been harmed,
 27 but a movement beyond disciplinary neoliberal frames of responsabilisation
 28 and internalisation to community and state accountability, a kind of
 29 insurrectionary safety ... operating within an abolitionist habitus.... How
 30 can we organise our communities to be safe? What should we do when
 31 various kinds of harm, with different kinds of needs, occur? What are the
 32 collective ways and forums in which we can pursue this work? (Cited in
 33 Sim, 2018b: 181–3)

34
 35 The issues raised by abolitionists resonate with the desperate situation in Liverpool.
 36 Placing safety and protection at the centre of the regime, and ensuring the democratic
 37 accountability of prison staff, are two issues raised by INQUEST, which has utilised
 38 an abolitionist perspective to frame many of its policy and practical interventions
 39 into the debates about deaths in custody. Over and above demanding a halt to the
 40 prison building programme and diverting those involved with the criminal justice
 41 system away from prison to well-funded and well-staffed community alternatives, the
 42 charity has also called for the creation of ‘a national oversight mechanism to monitor
 43 deaths in custody and the implementation of official recommendations arising for post
 44 death investigations’ (INQUEST, 2018b: 9). This would be tied in with ensuring:

45
 46 accountability for institutional failings that lead to deaths in prison. For
 47 example, full consideration should be given to prosecutions under the
 48 Corporate Manslaughter and Corporate Homicide Act, where ongoing

1 failures are identified and the prison service has been forewarned (as with
2 Liverpool and Nottingham prisons). (INQUEST, 2018b: 9)

3
4 Forensically detailing and recording the ‘buried and the disqualified’ knowledge and
5 experiences of prisoners and their families has been central to the work of INQUEST
6 and other abolitionist activists groups. It can be seen as representing an ‘insurrection
7 of subjugated knowledges’, thereby directly challenging the state’s definition of penal
8 reality and acceptable penal policies (Foucault, 2003: 8, 7). In that sense, abolitionists
9 have relentlessly searched for, found and exploited the ‘the cracks, silent tremors and
10 dysfunctions in institutions’ (Foucault, 2002: 458). Their goal has been to speak truth
11 to the state while attempting to force the state to speak truth to the wider society.
12 In the context of the ‘unprecedented levels of secrecy, obfuscation, dissembling and
13 downright lying that now characterise public life’ (Panitch and Leys, 2005: vii), this
14 remains a difficult, though not impossible, task.

15 As with any hegemonic intervention, this process is incomplete and is made more
16 difficult in the current neoliberal conjuncture by the limpet-like relationship between
17 liberal reform groups and the state’s prison agenda. That limpet-like relationship
18 extends to liberal academics, whose research, often based on snake-oil criminological
19 theories and methods, and debatable funding streams, allows them to work, often
20 obsequiously, with the state, asking for reform rather than demanding radical change
21 (Mathiesen, 1980). There are significant ethical and political issues generated by the
22 existence of this prison–academic industry in the 21st century. Liberal academics
23 *know* what is happening daily in decrepit institutions like Liverpool yet they persist
24 in seeking out grants, from whatever source, in order to search for, and discover,
25 the golden fleece of penal reform, a quest that is as meaningless as it is unachievable.

26 The endless search for the ultimate reform is based on a ‘bastardised conception
27 of political reality’ (Unger, cited in Williams, 2013). This means that a proposal or
28 policy for change is considered realistic ‘to the extent that it approaches what already
29 exists’ (Unger, cited in Williams, 2013). Penal policy provides a particularly clear and
30 grim example of Unger’s thesis. ‘What already exists’ remains both the starting and
31 finishing point for the debate around prisons. Policies and practices that step outside
32 of ‘acceptable’, common-sense and political penal realism, as well as individuals
33 and organisations who refuse to accept ‘what already exists’, are contemptuously
34 regarded as unrealistic or are constructed as pro-crime and anti-victim, an ironic and
35 offensive label given the levels of domestic and sexual violence against women that
36 state institutions, and successive governments, have consistently ignored, and indeed
37 legitimated, through their inept and lamentable responses to this violence (Sim, 2009).

38 Unger’s point helps in understanding the official response to the report on Liverpool.
39 Closing down the debate through focusing on the highly visible folk-devil, such as
40 the drug-taking prisoner (while ignoring the often-dubious use of officially prescribed
41 drugs in prison), kept it within the ‘realistic’ discourses that have been established
42 and remain deeply embedded within the state and those responsible for running and
43 managing prisons. It simply reinforced ‘what already exists’.

44 45 **Conclusion**

46
47 Liverpool was a parasitical institution that was *not* out of control. It was *in* control,
48 heightening the fears and anxieties of prisoners to often unbearable levels while

1 brutally extinguishing any hope that they could change for the better. Their aching
2 desolation, and physical and psychological dismemberment, was ignored at every
3 level of the state. Prisoners were barely existing in a mortifying regime where ‘casual
4 cruelty flourish[ed]’ (Medlicott, 2001: 256).

5 Prison managers were invisible. They failed dismally to control the regime’s
6 purgatorial presence and protect the prisoners towards whom they owed a duty of
7 care. There was no circle of safety for them. Prisoners were bereft and left to fester in
8 a reeking, penal dustbin. There was an institutionalised taboo on empathy, pity and
9 mercy. Ironically, prisons are supposed to generate a sense of responsibility in those
10 they confine. Yet, prisoners in Liverpool (and the other institutions discussed earlier)
11 were detained in a ‘site of state confinement’ (Carlton and Sim, 2018) that epitomised
12 irresponsibility, complacency and indifference, underpinned by a punitive, hyper-
13 masculine, occupational culture. Trapped in these melancholic places, their sense of
14 terror was reinforced by the senseless, crushing, futile irrationality of the prison rules.

15 Given this toxic environment, it was not surprising that many prisoners in Liverpool
16 and other institutions – their purgatorial reality dismissed, discredited and disavowed
17 – chose to respond through using drugs and violence, engaging in self-harm, and
18 killing themselves. From the outside, these responses appear to be pathological
19 and meaningless. However, it is difficult to imagine *any* human being, whatever
20 their background, existing in such primal, piercing circumstances and not reacting
21 negatively. Institutionalised indifference, underpinned by the threat and use of state
22 violence, can break even those who have an iron will for self-preservation. The
23 report on Liverpool opened a space to contest the discourse of individual pathology.
24 It exposed the prison for what it was: a trauma-inducing site that further splintered
25 the lives and psyches of dispossessed individuals whose lives and psyches were already
26 splintered by the social and economic circumstances in which many of them lived
27 outside of the institution.

28 It also highlighted the contradictions within the state, in that state servants do not
29 speak with one voice. Peter Clarke, the Chief Inspector of Prisons, was a former
30 Deputy Commissioner in the Metropolitan Police and Head of Counter Terrorism
31 Command. He did not conform to the caricature of being ‘pro-crime, anti-victim’
32 that, as noted earlier, has been, and remains, the dire political response to individuals
33 and groups who criticise the state’s often-catastrophic policy failures in prisons and
34 the criminal justice system. This discourse was particularly prominent under New
35 Labour’s ‘authoritarian reign of piety and iron’ (Lowell, cited in Panitch and Leys,
36 2005: viii). It generated an unyielding, punitive focus on the alleged atavism of the
37 poor in order to change their feral subjectivities while, simultaneously, pursuing ‘light
38 touch’ regulation for the allegedly well-adjusted, responsible individuals working
39 in the financial ‘services’ industry, multinational corporations and criminal justice
40 institutions, including prisons (Sim, 2000, 2009).

41 So, while the Prison Inspectorate should be commended for providing compelling
42 evidence about the soul-crushing melancholia engendered by the regime in Liverpool,
43 and other prisons, the report’s limitations should also be recognised. Restoring the
44 penal status quo through state-sanctioned reform will only legitimate the prison’s
45 voracious capacity for punishing neoliberalism’s racialised dispossessed: in male
46 prisons, a hyper-masculinised, combustible combination of ‘social dynamite’ and
47 ‘social junk’ (Spitzer, 1975); in female prisons, overwhelmingly poor, psychologically
48 and physically abused women with mental health issues (INQUEST, 2018c). It also

1 ignores the institution's (and the wider criminal [in]justice system's) ideological and
2 material role in defending the amoral, brutal structures of power and domination
3 operating in a grossly unequal society (Sim, 2009).

4 At the same time, the social order of the prison, and the wider society, remains
5 brittle, susceptible to individual and collective acts of insurrection, contestation and
6 disorder. Nearly 50 years ago, George Jackson (1972: 95) captured that sense of fragility
7 when he wrote that 'the ultimate expression of law is not order – it's prison. We have
8 hundreds upon hundreds of prisons, and thousands upon thousands of laws, yet there
9 is no social order, no social peace'. Jackson's poignant insight remains directly relevant
10 to today, arguably even more so in the current neoliberal conjuncture. Politicians,
11 reform groups, liberal academics and media commentators might want to think about
12 the significance of his words if prisoners are to be protected, if state servants are to
13 be held accountable and if the scourge of the modern prison is to be abolished and
14 its stain removed forever from the social landscape.

15 **Funding**

16 The research for this article received no specific grant from any funding agency in the
17 public, commercial or not-for-profit sector.

18 **Conflict of interest**

19 The author declares that there is no conflict of interest.

20 **Acknowledgements**

21 Thanks to the two anonymous reviewers, whose comments considerably strengthened
22 the article's arguments, and to Kym Atkinson, Deborah Coles, Will Jackson, Will
23 McGowan, Rebecca Roberts, David Scott, Steve Tombs and Katie Tucker for discussing
24 different aspects of this article with me. Thanks also to Una Barr, Lindsey Metcalf and
25 Adam Westall for organising the 'Shut Up and Write' sessions at Liverpool John Moores
26 University (LJMU), where some of this article was written, and to the staff in Ebeltoft
27 Library in Denmark for providing such an excellent environment for writing other parts
28 of this article.

29 **Notes**

30 ¹ This article builds on a number of blogs I wrote that were published in 2018 by the
31 Centre for the Study of Crime, Criminalisation and Social Exclusion, Liverpool John
32 Moores University (See <https://ccseljmu.wordpress.com/2018/01/30/liverpool-a-broken-prison-in-a-broken-system/>).

33 ² This was one of 61 contracts that the company had signed with the state. Along with
34 Carillion, another private 'facilities management' company, in 2015, Amey, had won
35 contracts worth £200 million to provide different services to prisons (Corporate Watch,
36 2018).

37 ³ ACCT forms should be opened on prisoners who are thought to be at risk of self-harm
38 or self-inflicted death.

39 ⁴ These data reflected the longer, deeply embedded history of ignoring official
40 recommendations at the prison. Between 2012 and 2014, the Inspectorate made 288
41 recommendations. Only 34% were achieved, leaving 66% partially achieved or not
42 achieved (Sim, 2018a).

43 ⁵ This is taken from Bob Dylan's song *The Lonesome Death of Hattie Carroll*.

6. It is also worth noting that in his response to the Justice Select Committee report on Liverpool, the Chief Inspector pointed out that the failure to act on official recommendations was ‘sadly no more than a continuation of a trend I reported on in my last Annual Report, when for the first time we found that the number of our recommendations that had been implemented fell behind those that were not. It was all the more troubling that the Committee heard that senior HMPPS [Her Majesty’s Prison and Probation Service] leadership had relied on reassurances from HMP [Her Majesty’s Prison] Liverpool that previous HMIP recommendations, from our May 2015 inspection, were being successfully implemented. Michael Spurr, CEO [Chief Executive Officer] of HMPPS, told the Committee: “In May, before the inspection, the prison was reporting that 66% of the recommendations were green, on-track and being delivered.” As Mr Spurr commented: “That was not right.” Mr Clarke added: “When we inspected HMP Liverpool in September 2017, we found that a mere 25% had actually been achieved” (HM Inspectorate of Prisons, 2018a).

7. This is a phrase used by Lou Reed (cited in Beaumont-Thomas, 2018).

8. Thanks to Lucy McKay of INQUEST for alerting me to some of the Prison Inspectorate’s press releases on this prison.

References

- Armstrong, S, 2017, *The new poverty*, London: Verso
- Beaumont-Thomas, B, 2018, ‘We are the people who are desperate beyond emotion’: Lou Reed’s lost poetry to be published, www.theguardian.com/music/2018/mar/02/lou-reed-lost-poetry-to-be-published
- Campbell, A, 1997, Walton tops prison suicides, *Liverpool Echo*, 8 January, p 5
- Campbell, D, 2018, Understaffing and delays blamed for rising attacks on NHS staff, *The Guardian*, 17 April, p 9
- Carlton, B, Sim, J, 2018, Deaths in sites of state confinement: a continuum of violence and terror, in S Read, S Sotirios and A Wright (eds) *Loss, bereavement and the criminal justice system: Issues, possibilities and compassionate potential*, London: Routledge, pp 54–63
- Coles, D, Shaw, H, 2015, Deaths in detention, *Criminal Justice Matters*, 102, December, pp 9–10
- Corporate Watch, 2018, Government allowed Carillion staff to work in prisons without mandatory suicide prevention, <https://corporatewatch.org/government-allowed-carillion-staff-to-work-in-prisons-without-mandatory-suicide-prevention-training-outsourcing-amey/>
- Corrigan, P, Sayer, D, 1985, *The great arch: English state formation as cultural revolution*, Oxford: Blackwell
- EurWORK, 2017, UK: prisons officers protest over staff shortages and safety concerns, www.eurofound.europa.eu/observatories/eurwork/articles/uk-prisons-officers-protest-over-staff-shortages-and-safety-concerns
- Fitzgerald, M, Sim, J, 1982, *British prisons* (2nd edn), Oxford: Blackwell
- Foucault, M, 2002, So is it important to think?, in J Faubion (ed) *Michel Foucault essential works of Foucault 1954–1984*, London: Penguin, pp 454–8
- Foucault, M, 2003, *Society must be defended*, London: Penguin
- HM Chief Inspector of Prisons, 2018a, *Report on an unannounced inspection of HMP Liverpool by HM Chief Inspector of Prisons, 4–15 September 2017*, London: HM Inspectorate of Prisons

- 1 HM Inspectorate of Prisons, 2018a, Response by HM Chief Inspector of Prisons to
2 Justice Select Committee report on HMP Liverpool, [www.justiceinspectorates.gov.
3 uk/hmiprisons/media/press-releases/2018/02/response-by-hm-chief-inspector-
4 of-prisons-to-justice-select-committee-report-on-hmp-liverpool/](http://www.justiceinspectorates.gov.uk/hmiprisons/media/press-releases/2018/02/response-by-hm-chief-inspector-of-prisons-to-justice-select-committee-report-on-hmp-liverpool/)
- 5 HM Inspectorate of Prisons, 2018b, *Report on an unannounced inspection of HMP
6 and YOI Nottingham 11–12 December 2017 and 8–11 January 2018*, London: HM
7 Inspectorate of Prisons
- 8 HM Inspectorate of Prisons, 2018c, Urgent notification: HM Prison Exeter, [www.
9 justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/05/
10 Exeter-UN-letter-and-debrief-for-publication.pdf](http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/05/Exeter-UN-letter-and-debrief-for-publication.pdf)
- 11 House of Commons, 2018, *Justice Committee oral evidence: HM Inspectorate of Prisons
12 report on HMP Liverpool HC 751*, London: House of Commons, [https://ccseljmu.
13 wordpress.com/2018/01/30/liverpool-a-broken-prison-in-a-broken-system/
14 Accessed 14th February 2019](https://ccseljmu.wordpress.com/2018/01/30/liverpool-a-broken-prison-in-a-broken-system/)
- 15 INQUEST, 2018a, *Press release: Inspectors find further evidence of abject failures at HMP
16 Liverpool, one of the worst prisons for self-inflicted deaths*, London: INQUEST
- 17 INQUEST, 2018b, *INQUEST submission to the Health and Social Care Committee
18 inquiry into healthcare in prisons May 2018*, London; INQUEST
- 19 INQUEST, 2018c, *Still dying on the inside: Examining deaths in women's prisons*, London:
20 INQUEST
- 21 Jackson, G, 1972, *Blood in my eye*, Harmondsworth: Penguin
- 22 *Liverpool Echo*, 2018, 25 October, [https://www.liverpoolecho.co.uk/news/liverpool-
23 news/new-prisoner-dies-48-hours-15321869](https://www.liverpoolecho.co.uk/news/liverpool-news/new-prisoner-dies-48-hours-15321869), accessed 14 February 2019
- 24 Mathiesen, T, 1974, *The politics of abolition*, London: Martin Robertson
- 25 Mathiesen, T, 1980, *Law, society and political action*, London: Academic Press
- 26 Medlicott, D, 2001, *Surviving the prison place*, Aldershot: Ashgate
- 27 Ministry of Justice, 2018a, Follow-up evidence on HMP Liverpool, [www.parliament.
28 uk/documents/commons-committees/Justice/correspondence/Minister-of-state-
29 HMP-Liverpool.pdf](http://www.parliament.uk/documents/commons-committees/Justice/correspondence/Minister-of-state-HMP-Liverpool.pdf)
- 30 Ministry of Justice, 2018b, *Safety in custody statistics, England and Wales: Deaths in prison
31 custody to September 2018 assaults and self-harm to June 2018*, London: Ministry of
32 Justice
- 33 Ministry of Justice, 2018c, *Annual prison performance ratings 2017/18*, London: Ministry
34 of Justice
- 35 Panitch, L, Leys, C, 2005, Preface, in L Panitch and C Leys (eds) *The socialist register
36 2006*, London: The Merlin Press, pp vii–x
- 37 Prisons and Probation Ombudsman, 2011, *Investigation into the circumstances surrounding
38 the death of a man at HMP Liverpool in February 2010*, London: Prisons and Probation
39 Ombudsman
- 40 Scott, D, 2008, Creating ghosts in the penal machine: prison officer occupational
41 morality and the techniques of denial, in J Bennett, B Crewe and A Wahidin (eds)
42 *Understanding prison staff*, Cullompton: Willan, pp 168–86
- 43 Scott, D, 2016, Bloodbaths and prison staff: considering the actual state of our prisons,
44 [https://www.liverpoolecho.co.uk/news/liverpool-news/new-prisoner-dies-48-
45 hours-15321869](https://www.liverpoolecho.co.uk/news/liverpool-news/new-prisoner-dies-48-hours-15321869), Accessed 14th February 2019
- 46 Scott, D, 2018, *Against imprisonment: An anthology of abolitionist essays*, Hook: Waterside
47 Press
- 48

- 1 Scott, D, Sim, J, 2018, Prisons: dangerous for whom?, <https://ccseljmu.wordpress.com/2018/09/20/prisons-dangerous-for-whom/>
- 2
- 3 Sim, J, 1994, The abolitionist approach: a British perspective, in A Duff, S Marshall,
4 RE Dobash and RP Dobash (eds) *Penal theory and practice: Tradition and innovation*
5 *in criminal justice*, Manchester: Manchester University Press, pp 263–84
- 6 Sim, J, 2000, ‘One thousand days of degradation’: New Labour and old compromises
7 at the turn of the century, *Social Justice*, 27, 2, 168–92
- 8 Sim, J, 2004, The victimised state and the mystification of social harm, in P Hillyard,
9 C Pantazis, S Tombs and D Gordon (eds) *Beyond criminology: Taking harm seriously*,
10 London: Pluto, pp 113–32
- 11 Sim, J, 2009, *Punishment and prisons: Power and the carceral state*, London: Sage
- 12 Sim, J, 2017, Austerity, violence and prisons, in V Cooper and D Whyte (eds) *The*
13 *violence of austerity*, London: Pluto, pp 195–202
- 14 Sim, J, 2018a, Liverpool: a broken prison in a broken system, <https://ccseljmu.wordpress.com/2018/01/30/liverpool-a-broken-prison-in-a-broken-system/>
- 15
- 16 Sim, J, 2018b, We are all (neo) liberals now: reform and the prison crisis in England
17 and Wales, *Justice, Power and Resistance*, 2, 1, 165–88
- 18 Sim, J, 2018c, Nottingham and Exeter prisons: death, danger and dehumanisation,
19 [https://ccseljmu.wordpress.com/2018/06/25/nottingham-and-exeter-prisons-](https://ccseljmu.wordpress.com/2018/06/25/nottingham-and-exeter-prisons-death-danger-and-dehumanisation/)
20 [death-danger-and-dehumanisation/](https://ccseljmu.wordpress.com/2018/06/25/nottingham-and-exeter-prisons-death-danger-and-dehumanisation/)
- 21 Sim, J, 2018d, Beyond redemption: the barbarism of Birmingham prison, [https://ccseljmu.wordpress.com/2018/09/18/beyond-redemption-the-barbarism-of-](https://ccseljmu.wordpress.com/2018/09/18/beyond-redemption-the-barbarism-of-birmingham-prison/)
22 [birmingham-prison/](https://ccseljmu.wordpress.com/2018/09/18/beyond-redemption-the-barbarism-of-birmingham-prison/)
- 23
- 24 Sim, J, forthcoming, ‘Malignant reality’: mental ill-health and self-inflicted deaths in
25 England and Wales, in K Kendall and A Mills (eds) *Mental health in prisons: Critical*
26 *perspectives on treatment and confinement*, London: PalgraveMacmillan
- 27 Spitzer, S, 1975, Towards a Marxian theory of deviance, *Social Problems*, 22, 5, 638–51
- 28 Stevenson, L, 2014, *Life beside itself*, Oakland, CA: University of California Press
- 29 Thomas, J, 2018, They should have kept my boy safe, *Liverpool Echo*, 23 February, p 4
- 30 Williams, Z, 2013, Why does Wonga even exist? It’s a question no one on the Left
31 asks, [www.theguardian.com/commentisfree/2013/dec/17/why-wonga-exist-no-](http://www.theguardian.com/commentisfree/2013/dec/17/why-wonga-exist-no-one-on-left-asks)
32 [one-on-left-asks](http://www.theguardian.com/commentisfree/2013/dec/17/why-wonga-exist-no-one-on-left-asks)
- 33
- 34
- 35
- 36
- 37
- 38
- 39
- 40
- 41
- 42
- 43
- 44
- 45
- 46
- 47
- 48