

Welsh Affairs Committee

Oral evidence: [Prisons, Probation and Rehabilitation in Wales - Committees - UK Parliament](#)

Wednesday 12 November 2025

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Watch the meeting

Members present: Ruth Jones (Chair); David Chadwick; Ann Davies; Gill German; Simon Hoare; Ben Lake; Llinos Medi; Andrew Ranger; Steve Witherden.

Senedd Equality and Social Justice Committee member present: Jenny Rathbone MS.

Questions 69 - 114

Witnesses

[I](#): Alun Jones, Chief Executive, Healthcare Inspectorate Wales; Rhys Jones, Director of Assurance, Healthcare Inspectorate Wales; and Rachel Thomas, Director of Operations (Primary, Community and Intermediate Care), Cardiff and Vale University Health Board.

[II](#): Katie Dalton, Director, Cymorth Cymru; and Chloe Marshall, Wales Operations Manager, Nacro.

Examination of witnesses

Witnesses: Alun Jones, Rhys Jones and Rachel Thomas.

Chair: Good afternoon, everyone, and welcome to this oral evidence session of the Welsh Affairs Committee. My name is Ruth Jones, and I am the Chair of the Committee. I am also very pleased to welcome Jenny Rathbone, a Member of the Senedd and Chair of its Equality and Social Justice Committee, who joins us under Standing Order No. 137A. Welcome, Jenny—it is good to see you.

Today is the third oral evidence session of the Committee's inquiry into prisons, probation and rehabilitation in Wales. In our first panel, we will hear from the independent inspectorate of healthcare services in Wales and the local health board that provides prison healthcare services at HMP Cardiff. On behalf of the Committee, I would like to say thank you very much for taking the time to join us this afternoon. It is great to have you here, and we are looking forward to hearing what you have to say.

Before we begin, I ask Members whether they have any interests that they need to declare.

Simon Hoare: It is not remunerated, but I am the patron of the friends of my local prison in North Dorset.

Q69 **Chair:** That is very helpful, Simon. I will now start the questioning. Can the panel briefly introduce yourselves and your role, and outline the work of your organisation as it relates to the provision of prisoner healthcare?

Rachel Thomas: My name is Rachel Thomas, and I am the director of operations for the primary, community and intermediate care clinical board at the Cardiff and Vale university health board. My role spans the provision of community services for the population of Cardiff and the Vale of Glamorgan. That also includes the provision of healthcare services at HMP Cardiff.

As a health board, we employ approximately 50 whole-time equivalent staff who are permanently based inside the prison and who provide a range of professional roles. Those staff work seven days a week. Most work daytime hours, but we have staffing provision overnight. Our staff are integrated with Prison Service staff, and they are supported by integrated prison officers and residential peer support workers.

Alun Jones: I am Alun Jones, the chief executive of Healthcare Inspectorate Wales. I will start with a slight apology: I have a heavy cold, so it is a good job I am not there today. I am coughing a lot, so in a minute I will bring in Rhys, who will introduce himself and help me to give evidence today.

Healthcare Inspectorate Wales is the inspectorate of NHS services in Wales and the regulator of independent healthcare in Wales. It is a dual role, and



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we carry out many and varied functions, including some aspects of the Mental Health Act and IR(ME)R—the ionising radiation regulations. So we have a broad role.

We are quite small; there are around 85 of us—that is not 85 inspectors—working at HIW at any one time. We have to make decisions—sometimes difficult decisions—about what we do where and when. Our programme is informed broadly by risks, so we rely on intelligence to make decisions about how we use our resources. We often say we cannot be everywhere all the time, which you might understand, so we have to make decisions about how we spread our resources across the many parts of the healthcare system, including prison healthcare.

Our interaction with prison healthcare happens in a number of ways, but there are two main ones. First, when HMIP carry out an inspection in Wales, we attend that inspection with them. We provide a healthcare perspective that feeds into that process in an integrated way. We are also part of death in custody reviews, which are led by the Prisons and Probation Ombudsman. We put resources into that, which is helpful in two ways: I hope it is helpful to the PPO, because they are getting local input from us; it is also helpful from our point of view, because it helps us to learn about the quality and effectiveness of healthcare services in prisons.

There is a third way in which we discharge our role, and that is more reactive. If we become aware of particular concerns or problems with healthcare delivery within prisons, we broadly have the powers to conduct reviews of those services, and we have done that in the past—we might talk about that as we go through our evidence.

There are some nuances in the way that services are provided in Wales. Our powers allow us to follow NHS money, so anything provided by or for the NHS comes within our remit. We can also scrutinise and regulate certain services under the independent healthcare legislation, which feeds into the Care Standards Act. That is a long way of saying that one discrepancy in Wales is that we can neither regulate nor inspect services provided by G4S at Parc prison, because we simply do not have a remit.

I will stop there for now. I guess that what I have said goes for both me and Rhys, but I will let him introduce himself.

Q70 Chair: Rhys Jones, do you have anything to add to that? Obviously, what Alun said was quite comprehensive.

Rhys Jones: No, I have nothing to add to what Alun said about our role and functions. I am Rhys Jones, director of assurance at HIW.

Q71 Chair: My question to both Mr Joneses is, how does your organisation work with HMIP to inspect healthcare provision? You just alluded to G4S. Can you talk a little more about the G4S situation? I am interested to know whether that is treated differently. How does it work?

Rhys Jones: It does not necessarily alter the way we work in looking at the healthcare provided at HMP Parc. Predominantly, the nursing care and



large elements of the healthcare are provided by Cwm Taf Morgannwg health board, so they would sit within our remit as an NHS service. Historically, there have sometimes been challenges when services are privately contracted within HMP Parc. Technically, we would not necessarily have a role or remit to be able to scrutinise those services in the same way. Historically, that has not necessarily manifested as a problem or challenge. We have accompanied HMIP on inspections there, and we continue to carry out death in custody reviews. It is a nuance in Wales, given the status of that prison in comparison with the other prisons.

As I have said, there are slight complexities with regard to some of the services that prison privately contracts, which technically sit outside HIW's remit. Operationally, we have not felt that that challenge has been detrimental to the work we are doing with HMIP.

Q72 Chair: To clarify, are you happy with the current arrangements for how HIW works with all the prisons, including Parc?

Rhys Jones: Yes, we are content with how HMIP has a strategy role to inspect each prison in Wales. We feel that we inform those inspections in a key way by providing our expertise. We have examples where we have developed or enhanced our methodologies for dental inspections for use in the prison establishment, and they are used on HMIP inspections.

The duty for inspecting prisons lies with HMIP, which is why we have not chosen unilaterally to do our own prison inspections in the past, although we technically have the power to do so. Given HMIP's role, we have seen that as effective. We have a memorandum of understanding—*[Interruption.]*

We accompany HMIP on their inspections, and we sometimes follow through on those recommendations and act on concerns around prison establishments not following up and completing recommendations. We have undertaken our own review, for example, of HMP Swansea and governance of that establishment—*[Interruption.]*

Chair: I am going to stop you there, Mr Jones. I am sorry, but we can't hear clearly what you are articulating. I look to the sound engineers to help out, because we are not hearing what you are saying clearly.

Q73 Ben Lake: Thank you all for attending this afternoon. I direct my first question to Ms Thomas, if I may. It relates to the work that the health board does to secure the provision of healthcare for prisons.

I am particularly interested to know whether prisoners have any distinct healthcare needs, compared with the general population. Following on from that, how do you work with, in this case, HMP Cardiff to ensure that you identify the particular needs of inmates and deliver the healthcare they may require?

Rachel Thomas: The thing to note is that Cardiff is a category B remand and resettlement prison, and 71% of the men are under the age of 40. The prison has a high turnover rate, with 30% of the men staying less

than one month and 87% staying less than six months. These figures are important in the context of what I will say about health needs.

Looking at the prison's population: approximately 15% of the men come from a black and minority ethnic background; 70% have self-declared mental health problems; 51% identify as having a disability; and 30% notify staff on first reception that they have a drug problem.

The health board undertook a health needs assessment earlier this year. It was externally commissioned and written on our behalf. Part of that study looked at the incidence of long-term conditions in the prison. The report found that the incidence of conditions such as asthma, COPD and diabetes are significantly lower than that of the wider Cardiff and Vale community. The population's two biggest health requirements are around mental health and substance misuse.

In terms of your second question—how do we work together?—we have a very positive relationship with the governor of HMP Cardiff and all his staff. As two organisations, our staff work in partnership and are integrated on a number of levels, ensuring quality service and the safety of men.

From a health board perspective, there are three tasks that we focus on in terms of identifying needs. The first is around our reception and screening processes, and our wider responsibilities for the provision of primary care services and enabling men to access secondary care services. We spend a considerable amount of time collecting data through clinical records, analysing this data and benchmarking ourselves not just internally within Cardiff and Vale health board, but benchmarking ourselves against comparator prisons in the rest of the UK.

We also undertake significant patient engagement exercises, either through forums held on the wings or through patient surveys, where we seek lived experience. From the prison side we are helped enormously by prison staff with the initiation of the health screening process. Prison staff help to co-ordinate our logistics. They provide support for peer mentors who help us build relationships with men, particularly men who are new to Cardiff and may be new to the Prison Service. Mentors help men have confidence in healthcare staff, and they support them to engage with our services. The prison staff are key in facilitating and scheduling access to the services we provide onsite, and also in the provision of escorts for any men who need clinical treatment offsite.

We have ongoing support and monitoring. All our staff, whether they are prison staff or health staff, work together. We have two dedicated healthcare officers, and prison staff are trained to respond in an emergency. Key to this is operational collaboration, which leads to our governance structure. We provide health services under a partnership framework between the health board, the Prison Service and the local authority. A key point in that framework is the prison partnership board, which meets quarterly. Underneath that prison partnership board are a number of daily, weekly and monthly meetings. All that collaboration enables us to work together to identify health needs.

Q74 Ben Lake: That is very useful, Ms Thomas. Given Mr Alun Jones's illness, I will direct this question to Mr Rhys Jones. Ms Thomas outlined the detailed and comprehensive way in which the health board works with the prison to identify needs. Is that sort of working relationship reflected in the other health boards that cover prisons in Wales, in your experience as the regulator?

Rhys Jones: I would point towards a review we did in 2022. We did a specific review of governance arrangements looking at HMP Swansea because we had noted some repeated concerns. I mentioned the lack of progress on death in custody in HMIP recommendations. We were concerned about the oversight link between the health board and the prison. From that piece of work, we specifically pointed out that we felt there were weaknesses in that kind of health board governance and oversight, and then a disconnect with service delivery.

There were weaknesses around that kind of engagement between national policy oversight, and there were some concerns around board-level scrutiny at that health board at that point. The review identified operational gaps that affected patient care. We were finding that the health needs assessments were not consistently informing service planning or resource allocation at that time. That meant the healthcare provision for HMP Swansea was more reactive than proactive, and not necessarily aligned to the longer-term needs of the population. That, in a sense, was indicative of that point in time about three years ago.

From our point of view, there is a significant role for the health board in relation to designing and commissioning services to be in line with the needs of the population. There is variance across Wales with regard to what those needs might be. It is firmly within the health board's responsibility, using the mechanisms it has, to design services that meet those needs, whatever they might be in that area.

Q75 Ben Lake: I have a final follow-up question. You mentioned the Swansea health board. First, has there been an improvement since that report? Secondly, I believe I am right in saying that the other two health boards in Wales with prisons are Aneurin Bevan and Betsi. Are you able to comment on their relationship with their respective prisons?

Rhys Jones: In relation to the Swansea work, we issued a number of recommendations. The health board has given us assurances around what it is doing to improve. Through the subsequent HMIP inspections we have seen a recognition that there has been strengthening of what we found in our own review. There is a bit of follow-through there. There is a strong story to tell about how our review found issues, and how the subsequent HMIP inspection recognised improvement and a positive trajectory compared with when we did the work.

We have not necessarily commented specifically or sought to look at the other prisons around Wales because of the nature of the work we do on death in custody and the HMIP inspections. We have not necessarily sought to comment directly on the health needs assessments. I guess



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what we do, through our findings, is shine a light on the issues that are more prevalent in those prison establishments. That potentially indicates where there might be weaknesses in relation to that prison establishment. As Rachel mentioned, we know there are specific issues with Cardiff being a remand prison and having a heavy turnover of prisoners with distinct mental health needs and withdrawal related to substance misuse, for instance—and Swansea is not dissimilar.

That contrasts with HMP Berwyn and HMP Parc, which have a relatively more stable prisoner population. Managing the needs of those prisons is slightly different. The stable population allows for something more akin to a GP-style of care and a preventive focus. However, the prisoners also have slightly different needs. We know that from our work in relation to HMP Usk, which has an older population with multiple health issues and potentially more social care, mobility, accessibility, wheelchair use, dementia and end-of-life care issues. Through our work, we see the net result of that variance. I like to think that the things we find are those that need addressing through the health needs assessments.

Chair: Before I bring in Jenny Rathbone, can I make a plea for brevity? Your answers have been very comprehensive, but can you be as succinct as possible? We want to make sure that we can ask all our questions today.

Q76 Jenny Rathbone: I want to challenge you all on how we ensure that prisoners are getting as good a clinical service as they would on the outside. What are the challenges to achieving that?

Chair: Who would you like to answer?

Jenny Rathbone: Let's start with Rachel, as you have a particular area of responsibility. How do you ensure that the staff working in Cardiff prison are providing the quality service you would expect to see for all the population?

Rachel Thomas: All of the clinical services provided by Cardiff and Vale health board are delivered under the quality and safety governance framework operating for the health board's wider provision. The prison partnership board I referenced is a meeting that receives a series of datasets relating to service delivery. We share our waiting times with the men and the governor, and we actively seek prisoner engagement and feedback on our services. We are supported monthly by the IMB in terms of live issues within the prison.

Q77 Jenny Rathbone: You have already told us of some excellent work you are doing on patient engagement. What is the vacancy level? Do those staff also deliver services to the general population?

Rachel Thomas: The challenge to ensuring consistent equity is twofold. First, there is the high turnover of men. The level of service that we are able to provide is very reliant on the amount of time the men stay at Cardiff, as opposed to the length of their prison sentence. The other challenge that affects the consistency of services is around our recruitment



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and retention. We have higher sickness and vacancies in our workforce attached to the prison. But we are a large organisation, so where we have issues with the provision of a particular service, we look to bring in staff from elsewhere in our organisation to support continued service delivery. We try very much not to drop or pause a service as a consequence of staffing gaps.

We have a very comprehensive workforce and recruitment plan in place to address some of our issues. We have also undertaken some changes to our management structure to ensure continuity of care and continued integration and partnership working with prison staff.

- Q78 Jenny Rathbone:** Perhaps you could send us a note about that—we are limited on time. Is Healthcare Inspectorate Wales satisfied with the service that is being provided? It is quite complicated because of the nature of the people we are supporting. Is the funding sufficient? Do we ensure that the clinical governance arrangements are as good as they are in the local community, based on your inspections?

Alun Jones: I think we have probably answered part of that question already. The key is the governance arrangements and oversight. It is important that health boards make an assessment of the needs of individuals so that they can match that with some kind of capacity. It is not unlike the situation in the wider community, where health boards and health services have challenges in meeting the needs of locals. In general terms, we see an equivalent service for things such as GP clinics, nursing care for minor conditions and emergency responses to injuries. But as care becomes more specialised, it becomes challenging. For things such as mental health, chronic disease management and some of the things that we have already mentioned, it does become difficult. Governance is the key. We expect health boards to have in place quality governance arrangements that provide transparency around how the board is doing. We expect the boards to be inquisitive, and to seek feedback from prisoners, relatives or anyone else on the quality of the services. They should have mechanisms in place to see, "Did that go well? Does it need to go better? Is there unmet demand?" That is the key to improvement. It is certainly not a clean bill of health—that is my overall summary—but, on the other hand, it would not be for the wider community either.

- Q79 Jenny Rathbone:** What about stroke services? They cannot be provided in the prison. If somebody is thought to be having a stroke, do they get the attention of a specialist within four hours?

Alun Jones: I will take that because I was already talking, rather than because I am the best person to answer. I do not have any information in front of me that answers that question. I would expect prisoners to receive emergency care in the same way that anyone else would, but I do not have any specific evidence that tells me whether that is happening.

Rhys Jones: Similarly to what Alun said, through our work and certainly through our death in custody work we see that, whether it is stroke or other emergencies, there are sometimes challenges with conveyance to a



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hospital in a timely way because of the delay in getting the ambulance. I guess that is not that different from being in the community, but it does have an impact. It is sometimes a factor in the deaths in custody that we have looked at.

- Q80 **Simon Hoare:** None of us will have been surprised to hear from Ms Thomas about the issues of mental health and substance abuse and dependency. Those stark statistics stand out when comparing the non-prison and prison populations. Can we drill into those issues a little? It may well be that you need to provide an answer in writing. How many prisoners who have a mental health condition and/or a substance reliance or substance abuse problem had a pre-existing condition, or a pre-existing but untreated condition and/or dependency, before coming into prison, and how many contract a condition and/or a dependency while being or subsequent to being admitted to prison? Can you give us any statistical evidence on that, so that we can have a more nuanced understanding of the genesis of those problems?

Chair: Who do you want to ask?

Simon Hoare: I suppose Ms Thomas, and perhaps Rhys Jones may have a word or two on that.

Rachel Thomas: I am afraid I can only speak in general terms; I believe I would need to provide more detailed answers separately.

Rhys Jones: We do not have the figures or anything like that, other than the conclusions and findings from our work that there are challenges around the continuity of care, certainly when somebody is being taken into prison, around their immediate mental health needs, for instance. But we do not have the figures to hand.

- Q81 **Simon Hoare:** So those figures exist, but you do not have them to hand, which is perfectly fine—or is it that those figures do not exist?

Rhys Jones: I am not aware of the figures. It is not something that we have now.

- Q82 **Simon Hoare:** Do you think that is a data gap that might be worth filling?

Rhys Jones: I would hope and expect that the health boards, in particular, would have that data, because it would be imperative and key in designing the services appropriate to the needs of that prison environment or population. We would not necessarily have a direct role with regard to that kind of service design, so those numbers would not necessarily be something that we routinely seek.

Simon Hoare: Okay. We will look forward to receiving some sort of written submission on that. Thank you.

- Q83 **Ann Davies:** Ms Thomas, written evidence has described several failings in the provision of prisoner healthcare, and those include delays in accessing prescription medication, poor information sharing between health officials and prison staff, inconsistent and insufficient mental health



services, and significant delays in calling for emergency services. Do you recognise those failings? What should be done to address them?

Rachel Thomas: First, I should say that I can only answer your question in the specific context of arrangements at HMP Cardiff. In relation to accessing prescribed medication, I am pleased to say that we have GP cover over seven days a week, including weekends. As a prison and health board, while I cannot deny that there would have been delays in the provision of medication in the past, right now our provision is good. If confirmation from the community of the medication a patient is on is received, all medicines for individuals are reconciled within 24 hours.

We do face some challenges in accessing data from men who have arrived from England. However, we have a dedicated admin team, part of whose role is to get us the correct information for medication to be delivered in appropriate time.

I think you asked about mental health provision. Cardiff is an integrated primary and secondary care model, which is focused on stepped-up care provision. The primary care element of mental health services within Cardiff is good. We have mental health staff working seven days a week. We have a duty psychiatrist available 24 hours a day, seven days a week. We have a duty worker who reviews all new receptions. We also provide on the wings short-term, brief interventions—CBT and self-help—and we run some anxiety groups. From a primary care perspective, I think our provision is good.

We have some challenges on the secondary care side, particularly in relation to accessing secure in-patient facilities. There are delays, with longer waits for accessing psychiatric reviews within our prison. I should reference that the Royal College of Psychiatrists Wales was commissioned by the Welsh Government and HMPPS to review the provision of mental health and substance misuse services in Cardiff, and it made a number of recommendations to us, which we have acknowledged and are working through. So it is a bit of a mixed picture in that regard.

On emergency services, we experience delays, but I think our position is the same as all prisons in Wales. For men to leave the prison, they require an escort, and the conversation about escorts is an ongoing one. We have very comprehensive arrangements in Cardiff, but when there is an emergency, we have to work with the Prison Service to identify and facilitate staff to enable a transfer. The emergency services can come into the prison, however.

I think your last question was about data sharing. Could you clarify whether that was about cross-border data?

Q84 **Ann Davies:** It was, and especially with regard to women prisoners. I know you don't have women prisoners in Cardiff, but women from Cardiff would be going over to Gloucester—to Eastwood Park. How does data sharing work with regard to men from England who go into Cardiff, or for women from Cardiff who go to Eastwood Park? How do you share data?



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The NHS system in England doesn't read what we have in Wales, and vice versa, so there is a problem there. How do you overcome that?

Rachel Thomas: I cannot comment on the arrangements for women prisoners, I am afraid. More broadly, on men leaving Cardiff and going to England, it is fair to say that within Wales, data sharing between prisons works very well. We are supported by the Welsh Clinical Portal and SystmOne. Two groups chaired by Public Health Wales bring healthcare staff in Welsh prisons together to focus on clinical strategy and our digital strategy.

As you indicate, there are cross-border challenges, but in Cardiff we have put in place a number of mitigations to ensure that the border doesn't become a problem in terms of the continuity of care. One of our mitigations is allowing staff to access smart cards that can access the English clinical portal. We have done some work around enhanced electronic discharge summaries so that, when men leave us, there is a comprehensive electronic record of what has happened to them to be given to their community provider. I can't say it is perfect, but I can say that we try very hard in Cardiff to ensure that these challenges do not have an overly negative impact on the delivery of healthcare.

Q85 **Ann Davies:** I hope those smart cards are used for women who come back to Wales as well. This is my last question to you, Ms Thomas. Mental health has been flagged as an area of particular concern by the independent monitoring boards and prison governors. What more can you do as a health board to support prisoners in Cardiff? I know you are talking specifically about Cardiff.

Rachel Thomas: I should reference again the report written by the Royal College of Psychiatrists, which sets out the need for improvement within Cardiff. We are working to do that. As a health board, we have an implementation plan and a workforce plan that we are actively working against. I am afraid that I cannot give you any numerical data to answer your question, but perhaps I can provide you with some supplementary information afterwards.

Ann Davies: Lovely. I will not bring in Mr Jones, but if you have something to add, perhaps we could have some written evidence. Time is running away from us.

Q86 **Steve Witherden:** I would like to question all three members of the panel, but I will start with Ms Thomas. Are local health boards adequately funded to deliver the services required by prisoners in Wales? If not, what funding is needed, and who ought to provide it?

Rachel Thomas: I am sorry, but I do not think I am the best person to answer that question. I can comment on the funding arrangements for HMP Cardiff, but I cannot comment on wider policy arrangements in Wales.

Steve Witherden: Okay. I am happy to move to Mr Alun Jones, if the inspectorate feel that they can take this one.



Alun Jones: I appreciate the question. It is challenging to answer. From our point of view, in how we discharge our role, we do not look at the funding that is allocated to prisons. We just look at the services provided. It is not a money thing; it is a quality thing. That is not me trying to avoid answering the question—it is just not the thing we look at.

If I could draw a parallel with wider provision of healthcare in Wales, every health board in Wales would say that it wants more money. That might be the same for every trust in England. Increasingly, healthcare services in the UK have to make decisions about priorities. Perhaps the answer to the question lies not in whether there is enough money, but in whether health boards are prioritising the needs of prisoners enough.

Rhys Jones: I do not have much to add to what Alun said. We would potentially highlight the causes where there are funding deficiencies. If there are not enough staff in the service, for instance, that might be indicative of a funding need or issue. Our view is that whatever funding there is needs to be commensurate with that need. It comes down to that from our point of view. We would not necessarily look at the funding level itself.

Q87 **Steve Witherden:** Thank you. Judging by the answers, or lack thereof, that was a controversial question. Ms Thomas, how is the level of funding that prison healthcare receives currently determined? Are there any ways in which you feel it could be improved?

Rachel Thomas: As a health board, we plan and commission services for all our residents and our registered population. We are expected to manage changes in demand within the funding envelope that the health board is provided with. We spend approximately £4 million on the delivery of healthcare services at HMP Cardiff. Most of that funding is spent on pay. There is a division of responsibilities between the health board and the Prison Service. Things like health-related capital expenditure would be subject to the overall NHS capital constraints. It is difficult for me to advise you on how that can be improved. I am unable to answer that part of your question.

Q88 **Steve Witherden:** I would like to go to the inspectorate for my final question. Mr Rhys Jones, how can the funding and commissioning of services be made more transparent?

Rhys Jones: It goes back to what we were saying about the importance of governance being an effective way to manage and design services. It is a two-way process. Quality governance is to make sure that services are being commissioned, provided and designed in accordance with needs. That loop comes back to governance in terms of determining, where those needs evolve—because they will evolve over time, just as societal needs do—whether there needs to be a change in how that service is run and funded. We see that end of the service. As Alun suggested, it is not our role to look at the funding arrangements in and of themselves; rather, what we find is potentially symptomatic of a deficiency or a need to make changes to funding.



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From our point of view, transparency in governance is key. Whenever there is governance, it needs to be transparent. It needs to be something that can be held to account and visible. All those things would drive a service that runs more effectively.

Q89 Steve Witherden: Mr Alun Jones, would you like to add anything on transparency?

Alun Jones: I think transparency is good. It helps with things like benchmarking. If you want to compare expenditure per head of population or something like that, transparency around the numbers helps. With any benchmarking, you would want to understand why there is a difference. It might be because of the vulnerability of the patients, the demographic and so on. We do not expect everyone to be the same, but transparency helps with comparisons and explanations of funding and services.

Chair: Jenny Rathbone has a very short supplementary.

Q90 Jenny Rathbone: Do you ever have any conversations with your opposite numbers in England about the fact the UK Government have not increased the amount of money for prisons in Wales for 21 years?

Alun Jones: I have not had that specific conversation. I refer, for similar reasons, to the evidence we gave a minute ago—our conversation would be more about the quality of the services rather than the input in terms of the money.

Q91 Jenny Rathbone: But you recognise that improving the quality of services probably requires bringing in extra personnel, and they have to be paid for their services.

Alun Jones: Yes, if what you are saying is true—I am not suggesting it is not; it is something that I have only just learned from your contribution. Costs have gone up and I would think that that would lead to questions about whether the funding needs to rise as well.

Q92 Simon Hoare: The Committee has been told in written evidence that prison healthcare in Wales is “very disjointed”. I am tempted to say, not as a criticism, that your answers have understandably indicated that to be a true statement. Do you share the assessment that it is disjointed, and would you support bringing all prison healthcare under a national structure, with ultimate oversight by NHS Cymru?

Alun Jones: I am not a big believer in huge structural changes or that they necessarily create better services in and of themselves. If there are issues with the way that things are functioning, people need to look at the partnerships and the arrangements and so on, because whatever you create requires people from different parts of the system to work together. Different people with different roles need to work together, regardless of whether it is a national system or a local one.

I can see a value in a health board-led structure, as is the case now, because both ourselves and Ms Thomas have described how each prisoner is different in their own way. I think there needs to be a tailored approach



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to each one, because of the types of prisoners, the demographics and so on. I think if there is a problem, it is about making it work better. That does not necessarily require structural change.

Rachel Thomas: I think there are two points, and again, I can only comment from Cardiff and Vale's relationship with HMP Cardiff and our relationships with other health boards and prisons, largely along the M4 corridor. I think my colleagues would say that we feel we have good relationships with our neighbouring prisons and our neighbouring health boards, particularly among the staff who work in the healthcare arena. I suppose I would go back to Jenny Rathbone's question around ensuring good standards.

My second comment would be that it is difficult to judge yourself, given we currently work within our health boards on providing good services. We do rely on our colleagues from the IMB and from Healthcare Inspectorate Wales to advise and guide us on whether our services are out of kilter with the provisions for the wider population in Wales and comparator prisoner populations across the UK.

Q93 **Simon Hoare:** It sounds as if it is quite hard, notwithstanding possibly the best personal relationships on a professional level, to try to identify what is best, what good looks like, what cost-efficient looks like and what efficient looks like, as it is done board by board. Is that fair? It is not a criticism, but it is a reflection on what I glean to be the state of operation.

Rachel Thomas: It would be fair to say that we do not routinely share information in terms of operational performance with our neighbours. But as a health board, we take our responsibilities for delivering services very seriously.

Simon Hoare: I am not questioning that.

Rachel Thomas: You referenced earlier the health needs assessment that we commissioned, which has provided us with very comprehensive information specifically around the healthcare performance of services in HMP Cardiff against those comparator prisons. I think we compared with three other prisons in the UK with similar populations.

Q94 **Simon Hoare:** Notwithstanding your heavy head cold, chief executive, this one is directed at you. We have been informed of alleged instances of third sector organisations providing clinical services in breach of the Care Standards Act 2000, due to a failure to register with Healthcare Inspectorate Wales. Are you aware of these concerns, and what are the implications of care providers operating outside the legislative framework?

Alun Jones: The Care Standards Act is a very complex piece of legislation, and—

Simon Hoare: With respect, Mr Jones, I did not ask whether the Act was complex or otherwise. All Acts of Parliament are, broadly, complex.



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Alun Jones: I am attempting to answer your question by setting some context. The Care Standards Act is not just complex, but quite outdated, I would suggest. The point at which it came into being was a very different time. It is 25 years old.

Q95 **Simon Hoare:** Okay. You have added that caveat. Let me remind you of the questions I have asked you. Are you aware, or were you aware, of third sector organisations providing clinical services in breach of the Act, irrespective of its outdatedness or complexity? The Act is the Act, unless it is reviewed or revoked. Were you aware of that?

Alun Jones: The Care Standards Act exempts independent healthcare services, so they are not required to be registered. I would need to see the individual example and look into it. My view on what the Care Standards Act does, and its requirements, does not align with what you are saying, in a sense. These services would be exempt from registration with us.

Q96 **Simon Hoare:** So to be clear, you are not aware of third sector organisations providing clinical services that would be in breach of the Act because they were not registered?

Alun Jones: That is correct. I am not aware of examples where they would be required to register with us, because my belief is that they do not need to be.

Simon Hoare: Your belief?

Alun Jones: Yes.

Simon Hoare: You are the chief executive of Healthcare Inspectorate Wales. Surely you should know whether they have to be registered or not.

Alun Jones: Well, there is some complex—*[Interruption.]*

Simon Hoare: We have just conveniently lost you, Mr Jones; your sound disappeared just when we were getting to the punchline.

Alun Jones: Apologies. That was not intentional, I promise.

Simon Hoare: No, I wasn't suggesting it was.

Alun Jones: Could you just repeat the last question?

Simon Hoare: I am slightly surprised; you are the chief executive, and you said, "I believe." Surely you should know who or what should be registered.

Alun Jones: Taking you back to my answer about complexities, the Care Standards Act is complex, but—

Q97 **Simon Hoare:** With the greatest of respect, if I had asked you, "Is the Act complex?" you would have given me your answer. My statement is that all Acts of Parliament are, by definition, complex, but we still have to operate under them, complex or not.



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Let's break it down. Do third sector organisations have to be registered—yes or no? Are you aware of any third sector organisations that have provided clinical services without being registered and therefore are in breach of this—as you have now told us, on a few occasions, complex—Act of 2000?

Alun Jones: They are not required to register, and therefore I am not aware of any that are required to register, because they are not required to register. There is no answer to it, in a sense. As far as I am concerned, there are not any examples of services operating that should be registered, because they do not need to be registered.

Q98 **Simon Hoare:** Why do you think this Committee would have been informed in written representations that that is the case?

Alun Jones: I do not know, but if you have an example of something that you feel we have misinterpreted, or another example, it would be much easier to answer that question. I can put that in writing, if you like, if you want to give me the example.

Simon Hoare: I am sure there can be an exchange of information.

Alun Jones: The legislation does not require independent healthcare organisations—

Chair: Let me call that to a close. We will follow up in writing on that. Thank you very much, Mr Jones. Before I conclude this panel, I would like to make a closing remark.

I am grateful to today's witnesses for appearing before the Committee and giving evidence, but I am concerned and disappointed by the lack of detail and clarity there appears to be on many aspects of prisoner healthcare provision. I remain unclear as to how Healthcare Inspectorate Wales is holding health boards to account on their responsibility to assess and meet prisoner healthcare needs. Similarly, I have not been provided with essential stats by the health boards on substance misuse levels within prisons, as we asked for earlier. Given the prevalence of healthcare needs in prisons in Wales, that is deeply concerning.

The lack of detail shows that prisoner healthcare is not being taken sufficiently seriously. As a result, I intend to write to the relevant health boards and Healthcare Inspectorate Wales to request that evidence, and if necessary, I am prepared to request that the CEOs of the relevant health boards appear before the Committee. I thank you for your time this afternoon, but we will be following up on this.

Examination of witnesses

Witnesses: Katie Dalton and Chloe Marshall.

Q99 **Chair:** Before we begin the second panel, I would like to make a few remarks. Unfortunately, one of our witnesses on this panel, Stephanie Rogers-Lewis of Cardiff council, is unable to attend on medical grounds. We send our best wishes to Stephanie, and we thank her and Cardiff



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council for their willingness to give evidence to this inquiry today. We plan to take written evidence from Stephanie once she has recovered, and we encourage the other local authorities in Wales with prisons in their area to engage with our inquiry as Cardiff council has, because they have not up until now.

The other point I wish to make relates to the publication of the “Prisons and Imprisonment in Wales” 2024 fact file, which was published today, and authored by Dr Rob Jones of Cardiff University. The Wales-specific justice statistics that have been compiled by Rob have been a great asset to this Committee’s inquiry and paint a concerning picture of the state of justice in Wales. Pertinent to today’s session, the fact file notes that, “The number of those released from Welsh prisons without a fixed address to return to increased by 34 per cent in 2024”, and, “560 prison leavers managed by Welsh probation services were rough sleeping on the day of their release in 2024/25.”

I am sure Committee members will agree that those statistics highlight the importance of today’s panel on housing and the homelessness support available to prisoners in Wales. That said, let me turn to our second panel this afternoon—Chloe Marshall and Katie Dalton. Starting with Chloe, can you introduce yourselves and outline how your organisations support prison leavers in Wales to access housing and homelessness support?

Chloe Marshall: Hi, I am Chloe, and I work for Nacro. We deliver a number of services across Wales in this arena. We have some CAS-2 properties, which are temporary accommodation for people who are on bail or home detention curfews. We also deliver the dynamic framework accommodation service in north Wales, which is an accommodation advice service for individuals who are either in custody or on community orders and have an accommodation need.

We also deliver a lot of floating support and supported accommodation for people. That includes support for people in their own homes or in the temporary accommodation they might be residing in, and we provide accommodation and links to support for people. Not all of it is for people who are leaving prison; however, much of it is. We are working with, I think, about 200 people in our broader services, and in our accommodation advice services, we had in excess of 650 referrals last year for support for people in north Wales who were leaving prison or in the community.

Katie Dalton: Thank you very much for the invitation today, Chair. I am director of Cymorth Cymru. We are the representative body for providers of homelessness and housing support services in Wales. We are not a direct service provider, but we represent 80 organisations—predominantly third sector, not-for-profit charities and housing associations. We also have some local authorities in our membership too.

As part of our work to support the Welsh Government to develop their Homelessness and Social Housing Allocation (Wales) Bill, which is currently making its way through the Senedd, we engaged with over 300 people



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with lived experience of homelessness. That has included two visits into Parc prison and two visits to probation services. Although some of my members, such as Nacro, specialise in supporting people leaving the secure estate, the majority of my members will at one time or another be supporting people who have a criminal offending background.

Chair: Thank you both for appearing in person this afternoon. It is helpful to have you in the room with us, so that is great.

Q100 **David Chadwick:** Thank you both for being here. How consistent is the provision of housing and related support to prison leavers across Wales?

Chloe Marshall: As I mentioned, a lot of our provision, in terms of support services, is across north Wales. CAS-2 is across all of Wales, and that is a very high standard. We are held to a high standard by the MOJ on that, and I am happy to say that we have all four stars on all our accommodation on CAS-2.

On provision more broadly, the temporary accommodation that people often find themselves in on their first night and for quite some time after their release from prison does not meet their needs. It can often feel like we are maybe setting people up to fail, because they have not got everything that they need to thrive and survive. There is no stability in that. It can be a long way away from their support networks, such as substance misuse support or family—whatever that looks like. Our Welsh housing quality standard and Rent Smart Wales help to make sure that the standards in more permanent accommodation are, in most respects, good.

Q101 **David Chadwick:** To follow up on the consistency point, is it consistently good or consistently bad?

Chloe Marshall: Consistent across Wales. It is very difficult for me to talk about that because, as I say, our provision across north Wales will depend on the local authority. Some local authorities have huge challenges because of second homes, so there is not very much provision there. We have to take into account the environmental factors that each local authority has in terms of those challenges.

Katie Dalton: I would suggest that it is inconsistent, and that is often down to a number of factors. The nature of the length of sentences and the type of prison, in terms of shorter sentences, resettlement and so on versus longer sentences, can obviously have a huge impact on the ability to plan for release and plan accommodation. There is also the complexity of support needs; whether people have access to help within the secure estate and whether that continues on release; and the availability of housing stock, both permanent housing and temporary accommodation.

There are pressures on every single local authority area in Wales. We currently have around 11,000 people in temporary accommodation in Wales as a whole. That has stayed fairly consistent for the last couple of years, having grown since the pandemic. That means that, in some areas, there is no temporary accommodation left. Every local authority is under pressure, but there are certain areas where it is extremely difficult for the



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local authority to find anything. Therefore, it is thinking about being able to provide a roof over someone's head, and then about whether that is suitable for that person, given their offending background and the complexity of trauma and support needs.

There are a couple of things that try to help with consistency. First, there is the housing support grant, which used to be the Supporting People programme. That was got rid of in England, which has seen support services decimated over the border in England. My colleagues in England are very jealous of Wales having retained the Supporting People programme, now called the housing support grant. That means that every local authority and area gets ringfenced funding to spend on housing-related support services. I cannot overstate the importance of that in supporting people who are at risk or experiencing homelessness.

The other thing is the prisoner pathway, which you are no doubt familiar with. That was established following the Housing (Wales) Act 2014, in response to concerns about prisoners losing automatic priority need status in Wales. A lot of us raised concerns at the time, and that was established to try to improve how devolved and non-devolved agencies work together. Implementation is far from perfect. A lot of that is down to resources and willingness and ability to share information, but there is a consistent pathway that exists.

It feels like there is a framework there to be able to support consistency and provide appropriate housing support, but the current pressures on local authorities are making that really difficult. All the factors I have mentioned have a different impact on the ability to provide consistent support. There are a number of different agencies involved in different parts of the system in different locations, and sometimes that can be confusing for the agencies, never mind for the people within the secure estate.

Q102 David Chadwick: Thank you, Katie. What role does housing play in ensuring the successful rehabilitation of prison leavers when they enter the community?

Katie Dalton: For me, it is critical; housing is the foundation of everything else. If you do not have a safe and secure home, how are you expected to stay on your medications, access support services, engage in employment or education, or make sure that your kids are attending school and doing their homework? It is just impossible to do that without that secure foundation.

We know that people in the secure estate have huge levels of trauma. I have a bunch of statistics on adverse childhood experiences and the extent of those within the prison population in comparison with the general population. That has a significant impact on people's ability to access and maintain housing. If I am correct, the statistics suggest that if you are released from prison into homelessness, you are twice as likely to reoffend.



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It really is significant. As I say, it is foundational; everything else builds on it. It has been really difficult for many people in Wales to find a home in recent years, but I do think the removal of automatic priority need for prison leavers back in 2014 has significantly hampered the ability of people leaving the secure estate to access housing.

Q103 David Chadwick: Chloe, Nacro provides CAS-2 accommodation in Wales on behalf of the Ministry of Justice. How many people have you supported through this provision in the last year? Are there any plans to expand the number of places available in Wales?

Chloe Marshall: I do not have those figures, sorry; I do not manage the CAS-2 properties. What I do know from colleagues is that we have 1,350 properties across England and Wales, and I think we have 85 in Wales itself. Some of those properties—10%, I think—are for women, and we also provide accessible properties.

Q104 David Chadwick: What trends have you noticed in demand for resettlement support services?

Katie Dalton: I do not have any data on resettlement support services in particular, but the feedback from my membership in our annual surveys is that, for the past three years, there have been significant increases in both demand and complexity of support needs, when it comes to housing-related support services. The evidence I get from my members is that there is much more co-occurring mental health and substance use issues, which we know affect more people in the secure estate than the general population. A lot of frontline staff in housing support services face increased threats and violence and weapons within services, and multiple drug use that impacts on people's experiences.

While that is a commentary on the broader population accessing homelessness and housing support services, I think it would be fair to say that, within that, there are people leaving the secure estate who are significantly traumatised both from childhood, because of their various experiences, and from their time within prison, and are often self-medicating through use of substances.

When I spoke to some of the men in Parc prison and within probation services, one of the comments I heard a lot was that they work really hard to deal with some of their mental health issues and trauma and to get the right support within the secure estate, but when they leave prison, they really struggle to access mental health services, or even to get their medication continued post-release. That has a significant impact on their ability to do other things, such as access and maintain housing, and access employment.

Chloe Marshall: I echo a lot of what Katie has just said. I think that there is a great weight on people who come out of prison to be grateful that they have got a roof over their head, but it goes far beyond that in terms of temporary accommodation; there is a safety and dignity that we should be providing to people, in order for them to be able to really move on and create a stable base to continue their rehabilitation in the community.



Q105 Andrew Ranger: Thank you both for coming in today. As we have heard, multiple stakeholders are involved in co-ordinating housing and the relevant support for prison leavers in Wales. To give some examples, HMPPS has accommodation pathway co-ordinators, strategic housing advisers, specialist housing advisers and a prison resettlement team, all of whom will be involved in the process to varying degrees. Are there too many actors operating here, and could simplifying things lead to better outcomes?

Chloe Marshall: There are three main people that prison leavers come into contact with. There is a lot of strength in that, because it is a mixture of third sector organisations such as Nacro, housing and probation. Having the third sector involved is really important, because sometimes we find that there is some distrust in statutory services, and that means there is somebody there that people can feel safe with and start having conversations with. Everybody is bringing a different strength to the table, and I think it is more about how those roles are co-ordinated, including the more strategic roles that you mentioned in HMPPS. There is a real want and intent to co-ordinate and make sure that everybody is working together. We sit in a number of meetings that do different things but all have great strengths in terms of making sure that there is provision out there that works for everybody and is tailored to the needs of the individual rather than being a one-size-fits-all.

Katie Dalton: I agree with everything Chloe said. It sometimes feels like there are lots of different organisations involved, and for me it is about co-ordination and clarity of the different roles. I absolutely support what Chloe said about the mistrust that a lot of people have in statutory services. We know the statistics on adverse childhood experiences. We know that many people in the homelessness system and the secure estate will have experienced childhood trauma. Often, they will not have been believed by statutory services. They will have been failed many times, and that is why they have ended up where they are. Absolutely understandably, it is really difficult for them to trust what they see as an arm of the state.

Having third sector organisations that are able to advocate on behalf of people and be viewed as independent bodies that can challenge on behalf of people within the secure estate is really important, but one key thing is information sharing, and I hear from my members, the majority of whom are not statutory bodies, that getting information about risk, in particular, is really difficult. That is particularly relevant when people are trying to support someone to leave prison and access the appropriate accommodation and support. My members tell me that sometimes it feels like they are not having risk information shared with them because they are not trusted, because there is a worry that they may not accept the person into the accommodation or support, or because there is more concern about privacy and GDPR than there is about safeguarding and making sure people have the right support around them. These are key agencies that have a huge part to play in resettlement when people are leaving prison. Sharing that information with them so that they, to the



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best of their ability, can place someone in the right home, in the right place and with the right support vastly increases the chances of people being able to succeed.

There are a few things ongoing at the moment. I will probably mention the homelessness Bill a few times during this session, because there is some stuff in it that will really help with homelessness and release from prison. First, the extension of the definition of “threatened with homelessness” from 56 days to six months means that everything that revolves around prisoners leaving the secure estate will be able to happen much earlier. Instead of two months before release, which is just an impossible period in which to sort out housing for someone who does not have any, this will happen at six months prior to release, which will give all partners much clearer timescales to be able to put things in place.

There is also an expansion of the co-operation duties in the Housing (Wales) Act 2014, which at the time were restricted predominantly to housing bodies. Those are being extended to a range of public services, including health and social care, but also the secure estate and probation. It is really pleasing to see prisons and probation on that list, because there are other non-devolved parts of the UK Government that are not, namely the police and the Home Office. It is really positive. There needs to be agreement from UK Ministers, but so far those discussions are going positively and they have been included in the Bill. As well as that duty to co-operate, there is a new “ask and act” duty on public bodies to enable them, if they view that someone is at risk of homelessness, to pose that question early on and do whatever they can within their power to prevent that homelessness or to refer on to housing.

There is another really important part that is focused on co-ordination for the most complex cases. One group of people listed in this bit of the Bill is people leaving the secure estate, so there is recognition that in that group of people there are likely to be additional complex support needs. The duty in the draft Bill is that local authorities will work with other public services to co-ordinate the support around people who have more complex needs. Some really exciting things are coming down the road in the homelessness Bill.

The other thing will be getting rid of priority needs and intentionality, which so often, when I speak to people who have been in the secure estate, are the two barriers that prevent them from being able to get the help they need and, more often than not, lead to them being on the streets. That is a Bill in the Senedd, but something that this Committee and this inquiry should be paying attention to in terms of the impact on the justice system.

Q106 Andrew Ranger: Great. Thank you both very much. You have probably touched on the answer to the next bit already, but I would like to ask both of you this. The co-ordination between the resettlement teams and local authorities is obviously key, as is sharing information, which you have already mentioned. Is that working effectively—I am talking specifically about the local authority link—and are there ways it could be improved?



Katie Dalton: I think it is variable. The evaluation of the prisoner pathway back in 2019 raised several concerns from local authorities about the quality of information that was being shared with them and the timeliness of information. I think teams were very frustrated and feeling that they were getting inadequate information, at a late stage in the process. With so much pressure on local authorities, it was really difficult then to meet those needs, particularly where people leaving prison might have other restrictions on location or where they can live. That makes it particularly difficult.

I think the measures in the Bill I mentioned will help that process, but there are also some really good examples of good practice. A while ago, I spoke to a team from Taff Housing Association, who are predominantly based in the Cardiff area. They were going into a local prison—I think in Bridgend—a few weeks or months before engaging with the person on their housing needs, and they continued that support after they had left prison. There was the continuity of that key person following them through.

The other thing that I think the Committee would be interested in is the Built for Zero project, which is up in RCT. They are doing some really interesting work. They are using a by-name list to focus specifically on people leaving the secure estate, and they are really drilling down into the risks, the support needs etc. around people. They are able to work with partners far in advance of people being released, to try to make sure that they get the right support available. They have a designated offender management officer, who sits within the council and who goes out to prisons and meets resettlement officers. There are starting to be some really positive impacts from having a dedicated role that is focused on that. There is inconsistency and there are lots of barriers, but there are some examples of good practice happening.

Andrew Ranger: Thank you; that is really interesting. Chloe, do you have anything to add to that point about local authorities?

Chloe Marshall indicated dissent.

Q107 **Andrew Ranger:** That's fine. Katie, your organisation represents over 80 housing, homelessness and support service providers in Wales. Do you assess that there is sufficient clarity, co-ordination and collaboration between all those third sector providers in the work supporting prison leavers?

Katie Dalton: Yes. In most instances, the vast majority of the services provided by my members in relation to homelessness and housing support are commissioned by the local authorities, because of the continued existence of the housing support grant. There is a lot of rigour around the commissioning of needs assessments for what services should be commissioned and then, often, individuals go through a local authority gateway, through which the local authority can assess which organisation is best placed.



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The diversity of those organisations is really important, because for some people a more generic housing support service will be absolutely adequate for them, but others will need a particular specialism and there will be in some of those specialist organisations a higher level of expertise on meeting particular needs and a higher level of trust on the part of some people in some communities. The diversity of organisations is the strength.

The structures we have in Wales around the housing support grant enable local authorities to have, first, a really good grip on what is out there and, secondly, the ability to refer people to the most appropriate route. That is certainly what isn't in existence in England. Your colleagues in Parliament here are having to take through legislation and policy to try to deal with the wild west that there is in England. Our retention of the housing support grant has protected us against that.

Q108 Andrew Ranger: I have one final question. You touched on GDPR and information sharing; is that an issue between those 80 providers when you are dealing with these cases?

Katie Dalton: The most common reference I have is where statutory services are not willing or able to share information with non-statutory services. I have, however, had a very positive conversation with HMPPS on probation in Wales and whether housing support agencies can be included in the data-sharing protocol that it is developing. That sounds really positive. If that were to happen, it would be a game changer. My members are really trusted partners; they have a huge track record in making a huge impact on people's lives, and sometimes it is those process barriers that can get in the way. I just wanted to mention that positive conversation.

Chair: Before I go on, I should warn you that we are expecting votes shortly. The information and evidence you are providing is really useful, but please understand that, when the bell goes, people will leave the room.

Q109 Llinos Medi: I thank both the witnesses for being here. Welsh women who receive custodial sentences are sent to prisons in England. What challenge does this pose when you are trying to support them to resettle back in communities in Wales? The question is to both of you, but we will start with you, Chloe.

Chloe Marshall: Sorry, could you ask the question one more time?

Llinos Medi: Obviously, we have no women's prisons in Wales, so they go over to England. What challenges does that pose when they begin to be resettled back in communities in Wales?

Chloe Marshall: I think there are terrible challenges for the women. It is such a long way for their children to come and visit them. They are not able to build the relationships when they are in custody that would support them to find accommodation on release.



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Where we are operating at the moment with men in Berwyn, we are there, we are speaking to people and we are on the ground with them on a constant basis, whereas you would be having to try to set up, I suppose, video calls and things like that. We do not work with women leaving prison at Nacro on our HMPPS services or our MOJ services, but we do have experience of supporting women coming back into the community through our HSG services. We see a huge challenge for these women being placed in really difficult situations for them that can be quite triggering and feel very unsafe for them.

We have seen it create patterns of recalls and cycles of instability, because people do not necessarily want to stay in places where they have been put because the risk is so high. They may get recalled then because they are not being compliant with their licence agreement. Those are some of the experiences that we have seen on a local level around supporting women, but we do not work specifically with them in that area.

Katie Dalton: It is hugely challenging, and the stories are often heartbreaking. We know that such a large proportion of women in the secure estate have experienced violence and abuse themselves. They have huge histories of trauma and are now in a system that is going to retraumatise them over and over. The fact that we do not have a prison for women in Wales, and that they have to be placed outside the country, makes it so difficult for them to maintain family connections and to connect with services, such as housing. That makes it really difficult to facilitate resettlement.

I am definitely not advocating for a prison for women in Wales. My view is that there are far too many women on short-term custodial sentences; that is just enough time to disrupt people's home, to disrupt their ability to take care of their children, and to break down other relationships and access to services, but it is such a short period of time that it seems senseless, to be quite honest with you.

I would like to see a reduction in short-term sentences, particularly for women, and far more community-based approaches to supporting women, given the trauma, the abuse, the vulnerability and the exploitation they face. Once you are in that cycle and you no longer have a home, and you are looking to return across the border, the scarcity of temporary accommodation in every area of Wales means that you lose that element of, "Where is best to place this person?", and it is "Where is there space to put this person?", whether that is suitable or not.

I have heard too many stories of vulnerable women being placed in unsuitable temporary accommodation, not because the local authority thinks it is okay but because they do not have anywhere. Then the risks of further exploitation and abuse are absolutely huge. We are, as a system, failing those women, who have come from a cycle of abuse and are re-entering a cycle of abuse because they cannot access accommodation.

One of the areas that we do a lot of work on in Wales is Housing First. That is an internationally acclaimed model that is all about providing a



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home first and foremost for people who have the most complex support needs and who have often not been able to maintain a tenancy for a very long period of time. It provides them with stable housing without their having to prove tenancy readiness or jump through hoops, and it then puts intensive multi-agency support around them.

We are also an advocate for Housing First for women. Where we have Housing First services in Wales—they are in most local authority areas in Wales—we advocate for those teams to work with specialist women's organisations to make sure that their staff are trained and understand the particular challenges facing women. In an ideal world we would want to see the commissioning of Housing First services for women, led by specialist women's VAWDASV organisations that have that expertise and that specifically focus on the women who face the greatest complexity of support needs. I would suggest that there would be significant overlap with the women in the secure estate in those cases.

Q110 Llinos Medi: I have a follow-up on that. You recognise that there is a distinct complexity in supporting women and preventing them from being homeless. Have you any other examples where women are finding other challenges to being homed safely?

Katie Dalton: Generally, we are seeing a growing number of homeless women at the moment. Often, women's homelessness is hidden because of safety—real or perceived safety; women wanting to hide away rather than being as visible on the streets. But that means, of course, that they are hidden away from services and support, so that is more difficult.

There is a lot of shame and stigma, particularly for women who have lost the ability to care for their children and have had their children taken away from them by social services. There is a lot of shame around that. We know that there is so much around that—around motherhood and the ability of women to feel that they are able to take care of children. That can psychologically re-traumatise women and make it really difficult. Often, women might not want to disclose some of those experiences. Again, that makes it more challenging to make sure that their support needs are met.

Llinos Medi: Chloe, do you have anything to add?

Chloe Marshall: I don't think so, no.

Q111 Llinos Medi: Katie has already said that she does not feel that we need a prison for women in Wales. What is your experience?

Chloe Marshall: I would absolutely agree. I don't think it is the right way to support women. I think we need more things in the community to support them, not sending them off into places where they are going to be retraumatised—everything that Katie has already said.

Q112 Jenny Rathbone: First, to Chloe, how does the Ministry of Justice monitor the quality of the CAS-2 accommodation you provide?



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Chloe Marshall: I accidentally touched on this one earlier. I understand that the MOJ inspects every property every year. As I mentioned, they hold it to a really high standard. They have four levels, including gold star.

We obviously have checks in place to make sure we maintain that. We check properties before people come in and after, and weekly while people are in those properties. Things will include making sure that people have enough crockery, nice bedding and a bedside lamp—all the things that make somewhere feel like a home and not just another cell.

Q113 Jenny Rathbone: Evidence to the Committee has been received in two instances. This may or may not be CAS housing, but the Brynawel House residential rehab centre has described it in written evidence as “often sub-standard”.

There is then something called the Kaleidoscope project, contracted by Dyfodol, which has been commissioned by HMPPS. There are concerns there about non-registration.

It seems quite a complex landscape. A witness on the previous panel was saying, “Oh no, they don’t need to be registered.” But clearly, the quality of services provided to vulnerable people needs to be of a standard to ensure that those services are not doing harm.

Chloe Marshall: I completely agree. It is about giving people a sense that they deserve it, then people will feel more settled there and everything can build from that point. It is really important to have good accommodation to a high standard. People should not be left to feel worthless, because if they feel that they are worthless, they are more likely to act like they are.

Q114 Jenny Rathbone: Katie, you have already mentioned the challenges that local authorities face in placing people appropriately. What level of oversight and regulation of landlords are there in relation to the standard of accommodation where women or men are being placed? Obviously, Rent Smart Wales is involved, but what do your members feel is the level there?

Katie Dalton: There are a number of pieces of legislation that govern the standard of the accommodation. Some of those are UK legislation, such as the Housing Acts 1985 and 2004, which look at things like overcrowding and housing standards. As you mentioned, the Housing (Wales) Act 2014 deals with private sector regulation. There are a number of other things around health and safety, fire safety, electrical equipment safety, gas safety, and so on, that have to be there as the bare minimum.

Within the homelessness guidance that the Welsh Government have issued to local authorities, there is a consideration of those who are coming through the homelessness system and any health or disability needs, and therefore the location and suitability of the accommodation, family support, medical facilities, disruption to employment or education, and proximity of domestic abuse victims and perpetrators where appropriate. That is within the statutory guidance about considerations for



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local authorities. If you were to speak to them, they would say that they go out and check the accommodation that they are discharging duties into. They make sure that it is of an appropriate standard and that, when it is in the private rented sector, it is registered with Rent Smart Wales.

The difficulty is, what do we think is acceptable? Is it that basic standard that meets electrical safety and gas safety requirements, or is it something that feels more like a home? Within Wales over the last decade, we have been really focused and have developed our understanding of trauma much more and of what a psychologically informed environment means. It means going above and beyond those basic standards and trying to make sure that people have somewhere that makes them feel safe—physically and psychologically—and that feels like home.

For people leaving the secure estate who might want to reconnect with children, having somewhere that children can come and visit, and stay and re-engage, is really important, particularly for women. That is not always possible within the temporary accommodation that is available, given the pressures that there are.

There are ambitions to improve the standards, and I know there is not a local authority area in Wales that would not support that improvement. I have said this many times, but if I could go back 40 years and say to the respective Governments, “Keep building social housing,” I would because we are in a situation now where we have had decades of under-investment in social housing and we are dealing with the perfect storm. We cannot undo that under-investment within one or two Senedd terms; it will take a lot more focus and investment. Until that is achieved, local authorities are in a really difficult space. There is an ambition from everyone that, yes, we must meet those basic minimum standards but we would like to go much further and give people the therapeutic space that enables them to recover and rehabilitate.

Chair: Thank you very much. I am now going to bring the session to a close, but before I do, I thank Chloe Marshall and Katie Dalton for taking the time to appear before us in person today. It is really helpful. Thank you for your clear and honest evidence, which has been helpful to the Committee.