HOUSE OF COMMONS

Justice Committee

Oral evidence: Ageing prison population, HC 304

Tuesday 21 April 2020

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Watch the meeting

Members present: Sir Robert Neill (Chair); Rob Butler; James Daly; Miss Sarah Dines; Maria Eagle; John Howell; Kenny MacAskill; Dr Kieran Mullan; Ms Marie Rimmer; Andy Slaughter.

Questions 1 - 86

Witnesses

I: Professor Jennifer Shaw, Academic Lead, Offender Health Research Network, University of Manchester; Paul Grainge, Chief Officer, RECOOP; and Emily McCarron, Equality and Human Rights Policy Manager, Age UK.

II: Peter Clarke, HM Chief Inspector of Prisons; Dr Rosie Benneyworth, Chief Inspector of Primary Medical Services and Integrated Care, Care Quality Commission; Jan Fooks-Bale, Inspection Manager (Health & Justice), Care Quality Commission; and Dame Anne Owers, National Chair, Independent Monitoring Boards.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Professor Shaw, Paul Grainge and Emily McCarron.

Chair: Good afternoon everyone, and welcome to this virtual meeting of the Justice Committee. We are grateful to our support staff for making it possible for us to operate in this way during the current circumstances. We are grateful for everybody's forbearance. Hopefully, the technology will run smoothly so that we can deal with today's evidence session.

In the usual way, since this is a formal Committee meeting, we have to deal with declarations of interest. I am a non-practising barrister and a consultant to a law firm. Do any other members of the Committee wish to make declarations?

Miss Sarah Dines: I am a practising barrister, but I have not taken a case since my election.

Andy Slaughter: I am a non-practising barrister.

John Howell: I am an associate of the Chartered Institute of Arbitrators.

Rob Butler: I am a former non-executive director of HMPPS, and I was the magistrate member of the Sentencing Council until my election.

Chair: Mr Daly is a member of a firm of solicitors, as he indicated before. I will make that declaration for him.

Maria Eagle: I am a non-practising solicitor.

Kenny MacAskill: I am a former solicitor.

Q1 **Chair:** We are now in a position to start with our witnesses. Since we are not directly in the room, would each of the witnesses on our panel kindly introduce themselves?

Professor Shaw: My name is Jenny Shaw. I am Professor of Forensic Psychiatry at the University of Manchester. I am also a member of the independent advisory panel on deaths in custody.

Paul Grainge: I am Paul Grainge, the chief officer of RECOOP. We are a charity that works exclusively supporting the over-50s cohort, working with prisons and probation.

Emily McCarron: I am Emily McCarron. I am Equalities and Human Rights Policy Manager at Age UK.

Q2 **Chair:** Thank you very much. This borders on the whole position of older people in prison, but obviously there will be some topical things because of the impact of covid upon us all as well.

We have seen quite a lot of written evidence about the definition of older prisoners. It seems that the UK follows the international practice of using the benchmark of somebody over the age of 50 for defining that cohort. That may seem unusual to people outside the prison system, who might think in terms of 60-plus.

Would you broadly agree with the categorisation of over 50 as being

appropriate? Why do you think it should be at that comparatively lower level compared with the way it is normally treated in the rest of the population?

Professor Shaw: This has been around for a while in the international literature. It was recognised by the Prison Reform Trust in the early 2000s that people over 50 in prison have characteristics, in particular their healthcare needs, which are similar to those in their 60s in the community.

There has been much debate about it. Some people agree. Some people say there should not be a cut-off on age alone and that it should be on need. However, we did a study in 2012 where we looked at the healthcare needs of those between 50 and 59, and those between 60 and 69 in prison. We found that the physical and mental healthcare needs of those two groups were very similar. Therefore, we concluded that it was appropriate to consider the age cut-off at 50.

Q3 **Chair:** Does anybody disagree with that? It seems to be generally supported. Are there any other points that people want to make as to why it is capped off? Given that we have that, and given that the number of people who fall within that cohort has increased significantly over the last couple of decades, first, to what extent is it appropriate to treat prisoners in the category over that age cut-off as a distinct group in the population? Secondly, to what extent is it actually possible to do so?

Paul Grainge: You broke up slightly, but I think what you were asking is whether it is appropriate to provide an alternative regime for that cohort.

Q4 **Chair:** The phrase I used was to treat them as a distinct group. That may be in terms of regime or other matters. Is it possible?

Paul Grainge: I think it is possible if you have the right amount of resource. There are aggravating circumstances whereby a significant number have been sentenced for sexual offences. That makes it particularly difficult for the operational team to segregate them in prisons where that segregation is in place. It obviously takes additional resource, which is not easy at the moment with the current pressures the prisons face.

In relation to the actual cohort themselves, particularly around their health and social care needs, they have a unique set of needs that is different from the younger cohort. For those looking to stay in prison, and who are not looking for education or to get into the workplace, or are not able to because of their health or mobility issues, there are alternative regimes for purposeful and meaningful occupation and independent living skills. They are similar to the types of skill and development someone would need if they were coming out of hospital so that they can adjust when they come out. It is unique to that cohort, and it is important that they have an opportunity to be recognised by being allowed to have an alternative meaningful and purposeful activity regime to help them in that way.

Q5 **Chair:** Ms McCarron, perhaps you could touch on whether you have found that that is deliverable in practice.

Emily McCarron: Older prisoners certainly need regimes that are suitable and reflect their needs. That is partly because, without proper or suitable regimes, their social isolation and marginalisation increase, which in turn has an impact on their health and wellbeing.

There are some good examples in a few prisons where there have been some alternative partnerships put in place. Age UK Wakefield worked in partnership with HMP Wakefield to develop a kind of support programme for older prisoners. There is another example in HMP Northumberland with Age UK North Tyneside, where they have developed a gym that caters for the needs of older prisoners. There is certainly an argument for alternative regimes that meet the needs of a different cohort.

Q6 **Chair:** Are there any particular characteristics that distinguish the older prisoners? Professor Shaw, what are your thoughts around that?

Professor Shaw: I agree entirely with what my colleagues said about the regime. The other consideration is whether they need separate units. There has been a bit more debate about that. There are certain advantages. You could have staff trained in knowing about the needs of older prisoners. You could make environmental changes that are more appropriate for older people.

There are certain disadvantages as well. If you create special units, they are likely to be at a distance from the person's home, so visiting is more difficult. There have been some studies where prisoners have been asked, and some prisoners do not want to be segregated with older prisoners. They quite like being with younger prisoners, but others do not. There is an element of choice and there is probably a need for both: some specialist older prisoner units for those who need or want them, and regime changes across the board for those who want to stay on the wing with younger prisoners.

Q7 **Chair:** Some might say that there is a distinction in the nature of what the prisoner has come in for. About 45% of people in the cohort are generally serving for sexual offences and sometimes will themselves be vulnerable within a prison setting from other prisoners. That may require a different approach from those who might, for want of a better term, be chronic offenders or repeat offenders who may have committed acquisitive or dishonest offences of one kind or another over a long period of time, and are serving their sentence quite late. Perhaps those people are often happier to be in the wing with younger people so that they do not feel potentially threatened or at risk from others.

I do not know if that is right or wrong. I get the sense that there is a bit of nodding of agreement with that as a proposition. Are there any other points around the characteristics that anyone wants to add?

Emily McCarron: I would argue that, while there is a need for specialist wings, there is also a need, with an ageing population that is only going to get older, to develop the concept of age-friendly prisons, so that

prisons are able to adapt to the needs of a prisoner at every stage of their sentence; the prison environment can adapt to the life course of a prisoner. They are not necessarily segregated simply because of their age. There might be an argument for specialist wings to do with the type of offence committed, but people are not segregated solely on the basis of chronological age.

Q8 **Chair:** There might be physical needs for separation—for wheelchair space, design of the wings of the building and so on—that you have to take on board as well.

Emily McCarron: Yes. I was thinking of a more holistic view of the development of prisons so that people are not necessarily isolated, because that indeed causes problems.

Q9 **Maria Eagle:** I am particularly concerned about the risks to older prisoners from covid-19. We know that there are outbreaks in many of our prisons. Could Professor Shaw give us an overview of the health profile of older prisoners? We know that some types of health issues make one more susceptible. Could we begin by getting a sense of the health profile of older prisoners and how their healthcare needs might be different in normal times from those of us who are in the community, and perhaps from younger prisoners as well?

Professor Shaw: Older prisoners—those over 50—have more complex needs than either older people in the community or their younger counterparts in prison. There have been studies that have looked at various aspects of that.

On physical health needs, studies over recent times, including one of our own, show that around 80% of people over 50 have some kind of physical health problem. The most common ones are cardiovascular problems and things like diabetes.

Secondly, they have high rates of mental health problems. Between 50% and 60% of people over 50 had one or more mental health problems, the most common being depression. We know from a recent study that we have done that there are higher rates of dementia in prison compared with the general population; 7% of the prison population have possible dementia or cognitive impairment. It is about 1% in the community.

They have more in the way of social care needs. Again, a study we did a while ago showed that around a third of older prisoners had some kind of social care problem. Their problems are multifaceted and complex.

Q10 **Maria Eagle:** Is there a difference between older men in the prison estate and women in the women's estate in terms of health needs generally?

Professor Shaw: The studies that have been done have focused on men because there are not many older women prisoners over the age of 50. The studies that have been done have tended to focus on men. In our study on dementia we looked at all the women's prisons and were able to

separate the men and the women. We found that the women also had higher rates of dementia than in the community.

The only other study that has looked at women in any detail was a study looking at social care needs in the States. It showed that women had equally high problems with their social care needs and daily living skills. It was very similar to the men.

Q11 **Maria Eagle:** We know that certain profiles of people, including older people and people with some of the types of chronic conditions that you referred to, professor, as prevalent in older prisoners, are more susceptible to covid-19 than different demographics. Would you expect, with your knowledge and experience, there to be more of an issue about serious covid disease and the incidence of it being more serious in more people in a prison setting perhaps than in the community?

Professor Shaw: Yes, and importantly for older prisoners because of the things I have said—they have more physical health problems of the kind that is considered for things like shielding—they are likely to be more susceptible to covid. That would need consideration in looking at what to do and how to manage covid in the older population.

Q12 **Maria Eagle:** The NHS guidance says that people aged over 70 are at greater risk from coronavirus than younger people. We have heard about the concept of accelerated ageing when it comes to the prison population. Do you think it is possible that the age threshold could be lower for prisoners than the 70 that the NHS suggests is the age threshold for the community outside prison?

Professor Shaw: From what we said earlier, yes, it should be considered as lower because of the higher prevalence of physical health conditions.

Q13 **Maria Eagle:** As far as you are concerned, the people who are responsible for looking after our prisons should take that very much into account when they are looking at how to deal with covid in our prisons. We know that it is already in a lot of our prisons.

Professor Shaw: Absolutely. I think in the various measures that are being *[Inaudible]* population, we should have in our consideration older prisoners *[Inaudible]* for these people towards the end of their sentence. Again, this group of older prisoners should be prioritised, if possible, because they are likely to have more chronic conditions—

Maria Eagle: There are some noises.

Chair: I am sorry about the noise.

Professor Shaw: No, I am sorry—I lost my train of thought then.

That is the first thing to consider. The second consideration is that, if new receptions of older prisoners into prison can be avoided, obviously that would also be good.

The third consideration is whether there could be more consideration of compassionate release for people with serious health problems. In my

work on the IAP, we had a recent roundtable, combined with the Royal College of Nursing, where we looked at compassionate release. We found that it is very infrequently used. We concluded that the current mechanism for compassionate release and the process is not fit for purpose. Again, could some consideration for the more severely ill happen? *[Inaudible]* people who remain in prison. Obviously, people who need shielding are going to include a disproportionate number of people who are over 50 because of the increased prevalence of chronic conditions, and that will need consideration as well.

Those would be the steps that I think we need to think about in dealing with this.

Q14 **Chair:** Do either of our other two witnesses want to come in on those points?

Paul Grainge: I echo the comments about the compassionate release considerations. What we are experiencing in some of our own services is the older cohort all being moved on to similar landings and wings, with some good practice happening, so that they can contain and manage them in a much more robust and tightly managed way. That is helping those who need to be shielded, and those who need social care help and help with other health conditions that our buddy support teams are working with. We are pleased to see that and would love to see it widened.

Emily McCarron: I echo what my colleagues have said, particularly on making sure that in the response to the needs of older prisoners during this pandemic any quarantine or isolation must be proportionate, particularly for older prisoners with dementia. Just as the impact of being in isolation in the community is quite profound and has an impact on people's physical and psychological wellbeing, so, too, is the impact on older prisoners socially isolated in their cells during this pandemic. That must also be considered.

Q15 **Dr Mullan:** I want to try to quantify what you have talked about. You have talked about there being a higher rate in the 50s group of ill health or other attributes that we see in older populations. What extent are we talking about? Is it almost the same as a 60-year-old or half the rate? Can you try to quantify that a little bit?

Professor Shaw: A small number of studies have been done. Seena Fazel, my colleague in Oxford, looked at comparisons between older people in prison and older people in the community and younger prisoners. He found that, with self-reported physical health problems, 85% of older prisoners had a physical health problem, whereas the number was 65% in the community, and 45% of younger prisoners. The conclusion was that older prisoners have more physical health problems than a comparable group in the community and younger prisoners.

Q16 **Dr Mullan:** Is there anything that is not based on self-reporting that evidences it a bit more clearly?

Professor Shaw: The figures on self-reporting matched the other kinds of studies that have been done, including our own, which looked at medical records and documented physical health conditions. That was the only one that did that, rather than comparison with the community and younger prisoners. The figures were very high when you look at medical records as well—85% or 90%.

Q17 **Rob Butler:** I want to follow up with Mr Grainge on any specific concerns you may have heard from some of the older prisoners you work with. How much risk do they feel they are under, and are they suggesting to you that they should be considered for some form of compassionate release?

Paul Grainge: We are struggling to get in and work with our service users at the moment because of the lockdown, as you would expect. What we have managed to do is set up some conference calls with some of our peer supporters and buddies in the prisons who are helping those with health and social care needs.

The main challenge that they see is being able to get out, do their job and help those who are locked up. The biggest challenge they are finding is in being able to help the regime to support them to get their meals, clean their cells and get their medication, because of the pressure of just being behind their doors continually at the moment. That is the only feedback we are getting at the moment, I am afraid, because of the lockdown.

Q18 **Rob Butler:** Are the families of older prisoners that you work with pushing you for compassionate release? The balance that has been stressed by the Government throughout is that people who are high-risk prisoners cannot be released early. As we discussed earlier in this session, many of those older prisoners are convicted for sex offences that, by definition, make them high risk.

Paul Grainge: Yes, you are absolutely right. There are families that are pushing for it, but equally there is a cohort that are not necessarily going to be going back to their home family unit, and the accommodation available for them is in very short supply. Finding APs that cater for some of their physical and mobility issues makes it particularly difficult. It is a perfect storm for this cohort.

Q19 **Rob Butler:** Is there recognition that because some of these people are high risk it has to reduce the possibility of an early release?

Paul Grainge: It depends on how you look at reviewing the risk around their health vulnerabilities, in conjunction perhaps with the compassionate release policy.

Q20 **John Howell:** My question is to Paul Grainge. This conversation, in a way, has been looking in at older prisoners. What are you hearing from older prisoners themselves about their concerns about coronavirus?

Paul Grainge: Adding to the last comment I made, we are only able to get in contact with our buddies who provide support in prisons to the

individuals. We have not been able to get any of our staff in working face to face because of the lockdown restraints that have been implemented, as you would expect.

Our buddies are struggling just to get access to help anybody. Many of our service users with health and social care needs are locked up in their cells for long periods of time and are struggling to clean their cells. They are struggling with their own mental health, particularly those presenting with symptoms and diseases such as dementia. They are very confused and finding it very tough. It is a difficult and pressured environment, as you would expect, but we do not have a good flavour yet of the impact it is having on our individuals. It is only snippets that we are getting from some of our buddies.

Q21 **John Howell:** Do you think that the current measures being used to tackle the virus on the prison estate will be enough to protect older people?

Paul Grainge: I do not know what the best practice is. At the moment, I do not know if they are doing temperature checks. I do not know if they are fogging. I do not know if any of the very fast-paced learning and good practice coming out of care homes is being replicated in prisons. I know that there is some good practice, where they are isolating some prisoners on particular wings. I know that some of our buddy supporters have been moved on to the health and social care wings so that they can reduce the risk of cross-contamination by moving back and forth from wings they have been working on.

There is some good practice, but equally in some other prisons we are not seeing any of our buddies being released. They are stuck behind their doors and not able to help or provide any of the deep cleaning to prevent and control infection that they have been trained to do.

Q22 **John Howell:** What about early release of some older prisoners? Is that something that we should consider?

Paul Grainge: We should consider it. We have not seen any significant increase in numbers with our service users from the open estate. I would welcome a review of that and, in particular, the scope on which it is considered at the moment in the current climate.

Q23 **Chair:** Do you think that the scope is adequate at the moment or too restrictive?

Paul Grainge: I would say that it is too restricted. Compassionate release is the area where that could be considered, and risk could be reviewed in light of some of the mitigating factors around the ailments that some of our cohort have.

Q24 **Chair:** Emily McCarron, do you have any insights from Age UK's point of view on the issues we have been talking about?

Emily McCarron: This has been raised by my colleagues. Obviously, given that a very large percentage of older men in prison have been

convicted of serious sex offences, that is going to make them ineligible to be released temporarily. I agree with my colleagues about reviewing the position and the needs in releasing older prisoners on compassionate grounds. If that is not the case, I think there has to be an immediate focus on the needs of older prisoners in the prison system and how best to protect them.

The other issue to which I would draw attention is the easement of the Care Act under the Coronavirus Act and concerns about maintaining an adequate level of social care for prisoners in isolation. We are concerned that the easement of the Care Act will lead to a further reduction of the care available in prisons at the moment.

Q25 **Chair:** Professor Shaw, is there anything that you would like to add on those points?

Professor Shaw: Compassionate release is a very difficult consideration. It is risk versus risk, almost. It is like the risk of release versus the risk of covid. There is a third one, I think. We know that discharge into the community is not without its problems. The process of transition is difficult. That is a third factor that would need to be taken into account when considering this.

Q26 **Andy Slaughter:** This is continuing with healthcare, so it is primarily for Professor Shaw. I want to ask specifically about dementia and palliative care. As the early signs of dementia may not be that observable in prison conditions, do you think that we know what the extent of dementia cases is? Do you think that people are getting treatment, whether it is medication or something else, for early stage dementia?

When it comes to later-stage dementia and people who are suffering from severe disorientation and memory loss—this is perhaps a more philosophical question—what is the purpose of keeping them incarcerated rather than in a clinical situation if there is no option for rehabilitation? There may not even be any memory of the crime.

Professor Shaw: Taking each of those points in turn, we have just finished a large-scale study looking at the prevalence and needs of people with dementia and mild forms of impairment. What we found, as I said earlier, is that the prevalence is much higher; it is seven times higher than in the community.

The other thing that we found was that it was largely unrecognised. We found a much higher prevalence than was known about in the case records, so there is a whole issue about staff awareness—both prison staff and healthcare staff—of the early signs of dementia.

The second thing we found was that there is currently no well-established care pathway for people with dementia. It starts at assessment. There is none of the equivalent kind of provision that you find in the community, such as memory clinics and proper assessments of people with suspected cognitive impairment. The early part of the pathway is not well developed

in prisons. From that, the actual provision of care pathways is also not well developed.

We think a range of provision is needed. For those with mild cognitive impairments, we have said that prisons in general need to be more dementia friendly. There needs to be better signage and clocks, and all the environmental changes that would be quite easy to make on all wings to make them more dementia friendly. For those with more significant cognitive impairment, there could be a case for having specific units within prisons, where there is more expertise for the treatment of people with dementia and the provision of psychological interventions, and so on.

Your final point is about whether they should be in prison at all. Again, this goes back to the balance between security need and the needs of people with severe dementia. In the earlier stages of dementia, it may be that their risk is slightly increased, particularly if they have disinhibition. They may have more propensity to offend, but, as they get more impaired, the risk will naturally reduce, as you suggest.

What we need then is a range of facilities in the community—things like secure nursing home arrangements for those with physical health problems as well. They should have access to the whole range of facilities that are available to people in the community if the risk is very low. We do not have any of that particularly at the moment. There is a real need for development of the whole pathway of treatment.

Q27 **Andy Slaughter:** Similarly, on palliative care, deaths of older prisoners are a big factor. We have been given the figure that 86% of natural-cause deaths in prison are over-50s, and that the average life expectancy of a prisoner is 56. You would therefore expect palliative care to be a high priority. Is there any developed palliative care system in prison at the moment? Are there separate units or, as you say, care pathways? What consideration, on compassionate or other grounds, is given to release if people are clearly in the last few months of their life? Is there an established way, an unexceptional way, of moving them into non-custodial conditions?

Professor Shaw: Across the prison estate, there is patchy good development of palliative care. There are some excellent facilities that have been developed. Again, there is no strategic development. It has largely been people thinking, "This is a good idea," and developing it. It is not comprehensively commissioned. There is a need to look at that.

At the roundtable event that I was describing earlier, under the auspices of the IAP and the RCN, we had presentations on things like the Dying Well in Custody Charter. That is a Department of Health set of principles for providing end-of-life care in prisons. I think it needs to be adopted.

As I said earlier, the other thing that needs to happen is a consideration of compassionate release. At the moment, the numbers are incredibly small; for example, only a quarter of the people considered by governors

to be suitable for compassionate release were actually released in the last year. The numbers are tiny, only a handful of cases.

There needs to be definite consideration of overhauling the compassionate release system for people who choose it. The other thing that has come up in the literature is that some people do not want to be released. When studies have been done, some prisoners say that they would rather stay in prison. Obviously, other people absolutely want to be released.

Again, there is a range that needs to happen. There needs to be good palliative care in prisons that is comprehensive across the board and an overhaul of the compassionate release system.

Q28 **Chair:** Any comments from Mr Grainge or Ms McCarron on those points?

Paul Grainge: I echo the comments of my colleague. The secure care home model is worthy of further exploration. What we find with some of our service users in the open estate is that because they are presenting with such complex needs there isn't any move on accommodation for them.

A secure care home-type model could be piloted in the grounds of one of our prisons, where local authority assessments could be done and you could use some of the existing prisoners to train up as buddies in a formalised training programme to help resource it. We are at a point now where there are so many complex health and social care needs in our ageing prison population that perhaps an alternative needs to be explored sooner rather than later.

Emily McCarron: Drawing all of this together, given that there is palliative care in some prisons that is better than others—I would make the same comment on social care—I would draw attention to the need for a national strategy on the needs of older prisoners. We need to bring things together so that we have a holistic approach across the board to cater for needs at every life stage of the prisoner's experience.

Q29 **Ms Marie Rimmer:** Can we look at what the barriers can be for older prisoners engaging with the prison regime, given the disabilities that they might have, the mobility, sensory or cognitive problems and the significant numbers with dementia? Do prison regimes and staff generally give sufficient consideration to the needs of older prisoners?

What modifications could be made to prison regimes to suit older prisoners? What kind of purposeful activity is there for them? They might not be engaged in work or training, or even education. What do you think on those lines? What are your views, Emily?

Emily McCarron: Essentially, the prison environment is not designed for older people. As I said, there is widespread variation across the prison estate in terms of which regimes are being adapted to older people's needs. This goes for prisoners with dementia *[Inaudible]* social and leisure programmes that are on offer to prisoners. The need to offer adaptation in the working environment should be carried out.

They need alternatives that are suitable for their needs. That can be applied to the resettlement programmes as well, which are also not meeting the needs of older prisoners. If they have been in prison for a long time, they need specific resettlement training for when they leave prison. It is about adjusting the regimes and making sure that they are suitable and adaptable, and specific to the needs of older prisoners.

Paul Grainge: The voluntary sector can play a massive part in providing alternative regime solutions in this area. We currently run a number of day centres for the older cohort where we work on social interaction skills. We prepare them for resettlement and the transition back into the community. We have a bespoke resettlement course that is about the technology and all the other age-appropriate challenges for someone coming out.

We had a gentleman who came out just before Christmas who had served 52 years. It is very difficult for us to empathise with how difficult it must be for that person coming out and having to deal with hole in the wall, chip and pin and everything else that we now take for granted. There is a huge amount of work that can be done inside the prison on independent living skills for resettlement.

There are courses. There is a huge amount of wisdom and experience in the population itself that needs to be utilised to a far greater extent. It just needs a co-ordinated approach and a national strategy to drive some of those interventions and get them in place across the estate.

Q30 **Ms Marie Rimmer:** Do you think that the guidance and training given to the staff on managing older prisoners is sufficient? Do they come up with specific activities and pastimes for the older prison population?

Professor Shaw: Often they do not, but what we found with our dementia project was that, when we asked service users and staff to come up with solutions on things like the regime and how it could be better, they came up with some fabulous ideas. It is about being creative. I absolutely agree with my colleague about including the voluntary sector and working with prisoners themselves to say, "What does it need to look like?" They are full of ideas; it is just a matter of getting those ideas, trialling them and putting them into practice. The ideas are definitely there.

Q31 **Ms Marie Rimmer:** Is there a possibility that there is not enough of a voice for the older population in the prison regime? The younger the prisoner, perhaps the more capable they are in advocating their needs and desires, more so than the elderly. Are they lacking in voice?

Professor Shaw: Yes. There is research evidence that has quite clearly shown that. There is certainly anecdotal evidence to that effect.

Q32 **Rob Butler:** I am interested in getting a view on separate environments. I think that has been quite fully addressed by all the witnesses, with the pros and the cons. I wonder whether there is any argument for dedicated staff, as, for example, we have in the youth estate, even if they are in a

normal prison.

Paul Grainge: Absolutely. We find that sometimes the staff who have responsibility for equalities, where generally this cohort are looked after, tend to work a shift pattern. Sometimes they are on nights and sometimes they are off for two weeks at a time, and you do not get dedicated focus and support for the cohort. It is a secondary duty, so it does not necessarily get the time investment that it should. We would love to see a designated governor and a local prison plan to adapt the regime so that it meets the demographic of that particular cohort and the percentage of it they have. That would be really beneficial.

Q33 **Chair:** Ms McCarron, do you agree with that?

Emily McCarron: Yes.

Q34 **James Daly:** My first question for the witnesses is in three parts. What are the needs of older prisoners in resettlement programmes? How well do prisons meet those needs? What more needs to be done?

Emily McCarron: Previously, I touched on the fact that there are specific needs for older prisoners who have been serving very long sentences. As my colleague Paul referred to earlier, they need to be up to date with technology. Obviously, there are very specific health and social care needs. We know that often social care is not being carried over and that it is a bit patchy on release. There is a need for appropriate housing.

I would like to draw attention to the issues relating to family support. Maintaining family links is vital, but, if there has been a long sentence, in many cases they can dwindle. Family support may not be there upon release, or the family themselves might be ageing and face specific barriers. There are definite issues facing older people when they are released from prison. It is not always the case that the regimes meet the need. There is a need to focus on the specific needs of older people.

Q35 **James Daly:** I want to go on to a very important question. How easy is it for older prisoners to find accommodation after their release?

Paul Grainge: It is particularly difficult. Just under half are likely to be coming out to approved premises. Many of the approved premises are Victorian townhouses. They have limited flat disability-compliant ground-floor accommodation. They are up and down stairs, which is a struggle. There is not the resource in the AP provision to help people with orientation, building the community links that are so important to reduce fear and anxiety as they live and build social capital in a brand-new town.

The accommodation is really difficult. They know that they are only going to be there for a limited number of weeks before they have to move on, because there is a rolling churn through an AP. If they have specific offences, which might be sexual, finding accommodation they can move to that is compliant with their mobility or health issues is difficult because care homes are often out of the equation. They are also sometimes limited by what the police say in relation to their index offences on where they can or cannot live. It is quite a challenge.

Q36 **James Daly:** What could be done to ensure that no older prisoners are released and become homeless very quickly after their release?

Paul Grainge: I would like to see some designated accommodation for that cohort so that they have somewhere to come out to.

Q37 **James Daly:** How effective is continuity of healthcare and social care from prison into the community for older prisoners?

Paul Grainge: Forty per cent of doctors' surgeries need ID before someone can register with them. Just that for starters for someone coming out is a huge limiting factor if they want repeat prescriptions for medication. Many of our older men and women are coming out without a social care assessment or care plan travelling with them, because they have been released before social workers have knowledge of them actually being released. That pathway is not at all joined up at the moment, and it needs a particular focus.

I would ask that the scope of the model for operational delivery guidance for governors is extended to include APs so that we can join that up. That would be particularly beneficial.

Q38 **James Daly:** Let me interrupt you for one second. We have heard accounts of prisoners being released without prescription medication. Is that something that you hear regularly?

Paul Grainge: Yes, we do, unfortunately.

Q39 **Chair:** Does anyone else want to come in on the points that Mr Daly raised? Ms McCarron?

Emily McCarron: I have nothing further to add.

Professor Shaw: I entirely agree with my colleague. Because of the complex health and social care needs, there is a need for a sort of transitional case management approach, whereby somebody takes responsibility for holistically providing for the needs of older prisoners. The danger at the moment is that there is silo working, both in the prison and outside, and nothing joins up.

It is a transitional case management approach. We have seen it work for people with serious mental health problems. The older prisoner group would be absolutely prime for this kind of approach.

Q40 **Dr Mullan:** Have you done any work that has looked at the cost of some of the suggestions we have been talking about today, such as dedicated services in prisons, separate wings or all these extra things? What would be the cost implications to the Prison Service of having to implement them?

Paul Grainge: The only thing I can offer is that we deliver a buddy support service. We actually train prisoners to the national care certificate equivalent that we have adapted for prisons. Anecdotally, what we are getting from some of our healthcare colleagues is that the cost of resourcing healthcare professionals that is being picked up by these

buddies, when they are there 24/7 providing support, is significant in empowering people to stay healthier for longer. There is also a significant reduction in staffing for domiciliary care provision. In one prison alone, it was up to four healthcare professionals and two or three nurses, if that is of any use whatsoever.

Q41 **Chair:** It gives a bit of context. Are there any other observations on that? Have there been any studies on that topic?

Professor Shaw: There have been no health or economic studies that have looked at the range of provision that I was mentioning earlier, such as how much it would cost for a nursing home or what the numbers would be. That has not been looked at in that level of detail and is actually needed.

Q42 **Chair:** Do you think it should happen?

Professor Shaw: Yes.

Chair: We have talked about the national strategy. I think two of our witnesses, Emily and Paul, have already said they are in favour of it.

Q43 **Rob Butler:** As the Chair has just said, there has been mention of a national strategy and the advantages or disadvantages. Of course, there is already the model for operational delivery, which HMPPS published in 2018; it stretches to 47 pages, so it is fairly substantive and comprehensive. I wondered how far that model goes towards catering for older prisoners. If it does not go far enough, what do you think a national strategy per se would deliver that would be better?

Emily McCarron: The 2018 model for operational delivery for older offenders certainly provides a good basis for a national strategy, but ultimately the model for delivery is optional. That is why we are calling for an actual national strategy so that it firms up what needs to be carried out, recognising that older prisoners are a significant cohort, and that they will be even more significant in the future as the population ages. I guess it is about the implementation of that strategy and that it is not just an optional toolkit.

Q44 **Rob Butler:** Mr Grainge, I believe that your organisation was actually involved in contributing to the development of that strategy, or model, as it is described.

Paul Grainge: Yes, in the guidance we were. It looked at good practice that we shared. I would like to see something that has a bit more regulation and some performance measures, led by the Secretary of State, driving that. That would be really beneficial.

The voluntary sector needs to be included as well as service users in the development and scope of what a national training scheme for staff might look like. That would be important, as would a set of standards that could be rolled out across all prisons, as we talked about. It is important that the scope of the model for operational delivery needs to include APs as part of the release package.

Q45 **Rob Butler:** Picking up on the points you have all been making about through-care, do you believe there is an argument for a parallel or similar system to that which exists in the youth estate, where youth offending teams look after young people who come into contact with the criminal justice system, whether it is in the community or in custody? Is there scope for something similar for older people, or would that not be appropriate?

Paul Grainge: It would be an interesting idea as part of national strategy implementation. There is a huge amount of experience and knowledge in the voluntary sector, and they would love the opportunity to do some work like that.

Emily McCarron: While young offenders are legally a distinct group, I do not think that the same could be said for older prisoners. I do not think there is a case for separating them or distinguishing them. It is just the case that many older prisoners will have distinct needs that need to be identified, and they are not necessarily being identified. They are being lost in the background, so to speak. I do not think it is a case of distinguishing; it is just identifying the needs. That idea is worth exploring.

Professor Shaw: I agree entirely with my colleagues about the need for a strategy. It cannot just be a strategy. It would need to lead to operational delivery, which is mandatory. The model is nice, but it is optional. To get it driven across the prison estate and to get commissioned services, there would need to be a strategy and mandatory operation.

Chair: I thank the witnesses on our first panel. Professor Shaw, Mr Grainge and Ms McCarron, thank you very much for your time and for your evidence. We are very grateful to you for joining us. It is much appreciated.

Examination of witnesses

Witnesses: Peter Clarke, Dr Benneyworth, Jan Fooks-Bale and Dame Anne Owers.

Chair: Welcome, Mr Clarke, Dr Benneyworth and Dame Anne. Perhaps you could briefly introduce yourselves.

Peter Clarke: I am Peter Clarke, the chief inspector of prisons.

Chair: It is nice to see you again, Mr Clarke. On behalf of the Committee, I want to thank you for having agreed to extend your term of office. I know that you were due to finish in April, but due to the current circumstances and pressures of continuity you have agreed to remain until the autumn.

Peter Clarke: That is right, Chair. You are very well informed; I only received the letter myself within the last hour.

Chair: We are very pleased to see that continuity. We are grateful to you

for doing that.

Dr Benneyworth: My name is Rosie Benneyworth. I am the chief inspector of medical services and integrated care at the Care Quality Commission.

Dame Anne Owers: I am Anne Owers. I appear not to be on your screen, but I am chair of the Independent Monitoring Boards. I do not know why my picture is not coming up, but I am here.

Chair: We will see if we can sort that out for you, Dame Anne, but your voice is well known to us. It is good to hear from you again. Thank you very much.

You have heard us talking about some of the challenges in the longer term, but also in the immediate and short term, facing us with the older estate.

Q46 **Maria Eagle:** Hello to all of you, particularly Dame Anne, whom I have not seen for a while. I am interested in what is happening with covid and the additional vulnerabilities that some prisoners have. We know that there is perhaps already some extensive infection across the prison estate. I wonder whether all of you—perhaps one by one, starting with Peter—can tell us whether or not you are asking for, and obtaining, from the Prison Service, or from the Department, some kind of information about the age and pre-existing medical conditions of those who unfortunately have been infected, and those who even more unfortunately have died in our prisons of covid.

Peter Clarke: As you know, we suspended our regular inspection programme a few weeks ago, obviously on grounds of safety and so on. What we did immediately was to set up what we called an intelligence cell to try to inform us as to how we could return as soon as possible to some form of independent scrutiny of what is happening in places of detention. Part of that includes a daily update from the Prison Service and the Ministry of Justice. We get information from central Government as well.

It does not go into the sorts of details about individual cases. We do not get that. We get the broad figures that are largely already in the public domain. It has been helpful in informing our movement towards returning to what we are terming not inspection but scrutiny visits. We started that today in three YOIs in the youth custody estate.

Q47 **Maria Eagle:** Dame Anne?

Dame Anne Owers: We are getting some information from our boards, which is helpful to us. There are two things. One is the extent to which older and more vulnerable prisoners can be shielded, given the size of the prison population and so on. That, it seems to us, is easier, oddly enough, in prisons that have a larger number of older prisoners because it is easier to put people into separate units. The prisons we would be most worried about would be the local prisons, where there are small numbers, and it is very difficult to create the headroom to shield vulnerable people properly.

I was talking yesterday to the chair of the Littlehey board, where there have been three covid-related deaths, but those were all men who had been taken into hospital for other reasons. At least two of them had acquired the infection in hospital, so the transfer in and out of hospital has an effect. But, of course, those deaths have a huge effect on the rest of the prison population. Chaplaincies are playing a great role in trying to reduce anxieties among older populations.

Dr Benneyworth: We are working very closely with many of our partners, including HMIP, NHS England and Improvement, both on a regional and national level, to look at the data that is coming in. NHS England has a regular situation report that they share with us. We stopped our regular inspections about a month ago as well, but we have set up a series of mechanisms so that we can understand the data and understand what is happening, including an interim methodology to work with prison healthcare teams to understand risk.

One of the difficulties that we may find is that we do not have the same disease registers and the same mechanisms for extracting the data in the way GPs have, to be able to identify exactly who are the vulnerable population and who needs shielding. That will be a challenge.

Q48 **Chair:** I think you have with you your colleague, Jan Fooks-Bale, who is the inspection manager for health and justice at CQC. Ms Fooks-Bale, are there any observations from your experience in that regard?

Jan Fooks-Bale: We monitor remotely at all times, but obviously monitoring services at this time have to be remote. We are sharing intelligence with HMI Prisons and they are sharing their intelligence with us. Now we have access to the covid data, we are developing a set of key questions that we plan to put out on engagement with the registered providers of health and social care in prisons, to explore the more qualitative aspects and wider implications of covid-19, and the impact on delivering the normal service—business as usual—and how they plan to move towards recovery when the opportunity arises.

Q49 **Maria Eagle:** Could we have some views from everybody on the current measures to tackle coronavirus on the prison estate? We have to remember that these people are incarcerated, so they cannot take measures themselves to escape from the danger. Many of them are more susceptible, as we heard in our earlier evidence session, not only to getting covid-19 but to being more badly affected by it than perhaps the general population. Are you all satisfied that the current measures to tackle this in our prison estate are doing enough, particularly to defend and manage the risk for older and more vulnerable prisoners in our prisons?

Peter Clarke: Last week, we conducted the first of our short scrutiny visits, as we are terming them. That was by way of a pilot really. The learning from that was that there is clearly huge awareness of what needs to be done. The challenge at the moment is actually, within the confines of a prison environment, trying to ensure that social distancing

is properly carried out and that there is space for the various cohorts so that the practice is being carried out as safely as possible.

The learning from the first visit last week was that there is a shared responsibility between leaders, staff and prisoners to ensure that things are done as well as they possibly can be and as safely as possible. I think that responsibility, from what we saw, was accepted by all of those groups.

We are going to focus on the issue of social distancing during the visits we carry out this week. Next week, we intend to visit a group of local prisons where the problems of space and crowding are likely to be quite acute. We hope to have a much more informed, on-the-ground view as a result of those visits.

Dame Anne Owers: As I said earlier, and as Rosie was saying as well, one of the difficulties is identifying those who are vulnerable. As the Committee heard in its earlier session, prisoners are more likely to have underlying health conditions than others, and older prisoners are more likely to have quite serious and perhaps undiagnosed underlying health conditions. First of all, we have to establish who they are. Secondly, having established who they are, we need space within the prison to have people in a shielded and protected environment. That is quite a challenge.

The other challenge, which comes out of some of the Committee's concerns about dementia, for example, is that when you isolate people because they are vulnerable, and you isolate someone who has even mild cognitive problems, and certainly people with dementia, it is going to exacerbate their condition considerably if inevitably they are isolated from everybody else. That is going to cause additional concerns. It is difficult to see a way through that.

Dr Benneyworth: Our regulation covers the health and social care sectors very broadly. Many of the problems that we are seeing across those sectors are very applicable to the prison setting as well—for example, the safe use of PPE, infection prevention control measures, effective shielding, good advanced care planning, and not using blanket approaches to "Do not resuscitate" orders.

When we do our normal inspection programme, we see significant variation in the ability of establishments to meet the guidance and the standards that are set out. I imagine that is going to be very much the same, particularly around infection prevention and control. We know that there is significant variation in non-covid times, and part of our methodology will be to explore infection prevention and control, and understand how people are being kept safe.

Q50 **Maria Eagle:** What further measures, if any, do you all believe need to be taken to manage the risks to older prisoners in our prison estate from covid-19?

Chair: Jan, do you have a view on that?

Jan Fooks-Bale: It is what we touched on just now. Apart from the immediate risk of covid-19 infection, we need to look at the wider risks and the fact that people are being locked down for extended lengths of time, which has an impact on their mental health and wellbeing, and for some of them already potentially their mobility.

We also need to think about who may slip through the net while everybody is focused on covid-19 and ensure that the ongoing monitoring of people's long-term health conditions is maintained so that they do not become worse and end up in hospital, where we know that there is an increased risk of contracting covid-19 or, in the worst-case scenario, dying from non-covid-related issues.

Q51 **Dr Mullan:** We are talking about covid and obviously we all agree it is potentially a life-threatening condition. I want to understand what the legal framework is for non-life-threatening healthcare provision in prisons. Is there an expectation that people are entitled to exactly the same healthcare as the general public, or is it similar to whether or not we provide healthcare to people who are not entitled to be here? We give them emergency treatment, and that is fine, but we do not tend to provide them with elective services or non-essential services.

Dr Benneyworth: Our expectations when we look at services in prisons are the same as the expectations we would have in non-prison environments. We look at the same five key questions: is the service safe; is it effective; can people access it; is it responsive; and is it caring? That is the same approach as we would have in non-prison settings. We use the same set of regulations.

Dame Anne Owers: The understanding is that it should be equivalent to what is available in the community.

Jan Fooks-Bale: As you probably know, Dr Mullan, the Royal College of GPs set out a standard of equivalence. I think it was towards the end of 2018 or the beginning of 2019. It talked about equivalence not necessarily being exactly the same service provision but equivalence in outcomes for prisoners. That is certainly something we look for.

Q52 **Ms Marie Rimmer:** We know that to get single-cell occupancy we would have to release a further 15,000 people, and we have 1,700 prisoners who are over the age of 70, some of them even 80 or 90. Should the early release scheme that they are not eligible for at the present time—45% of the over-50s who are sex offenders are not eligible for early release—meet the needs of coronavirus?

Is there a case for release on compassionate grounds? Does it go far enough for vulnerable people aged 70, 80, and some of them over 90, who are sex offenders and who would not be considered for early release at present? Is there a case for extending it or at least for giving them priority in single-cell occupancy?

Peter Clarke: We have looked at some of the data, and it is the fact that more older prisoners, aged 50 or over, are held in single-cell

accommodation than those from other age groups; about 67% are held in single-cell accommodation. That means, of course, that about a third are not held in single-cell accommodation. With the current figures, that is somewhere just over 4,000.

As to whether there is a case for extending the early release scheme, that clearly is a matter of policy that is not within my remit. What we will be looking at very carefully is the treatment and the conditions for older prisoners who are being held in shared accommodation, and whether that is in any way compromising their safety and their health. I think there is a perfectly valid question about how we can make the more vulnerable prisoners as safe as humanely possible within the confines of the overall prison estate.

There has been a lot of public debate about the numbers in prison and so forth, but it is worth mentioning that the figures I saw yesterday suggested that in the past week there were 1,100 fewer prisoners than at this time last week. I do not know exactly why, where those prisoners were released from or whether it is a question of a higher number released or fewer being put into prison, but those are the figures that came to me yesterday. It is an interesting dynamic to look at—to see what is leading to that quite sharp decline in the space of one week.

Dame Anne Owers: We need to distinguish early release and compassionate release. There is a risk of mixing them up a bit. Early release is designed so that people who are coming towards the end of their sentence can be released if it is safe to do so. I am afraid that there will always have to be a balance between public safety and health in those circumstances. It is difficult to avoid that.

As some of your earlier witnesses said, early release is not as easy as it may sound because you have to release people to somewhere. The number of approved premises is quite small. It is even smaller because they, too, are trying to get down to single-room use, and for some of the people we are talking about there are not families to go back to. That will always be quite a difficult balance.

Compassionate release, when someone is at the end of life and therefore incapable of doing harm and may have somewhere to go back to, is a different question. Early release will always be a difficulty for all the reasons described and for the kinds of offences that many of the older population have committed.

Q53 **Ms Marie Rimmer:** Do we know how many of the over-70s, given that over-70s are being treated specially outside, at least have more consideration inside for single-cell occupancy? Do we know if there is any movement to accommodate them in single cells at least?

Dame Anne Owers: I think there is an attempt to do so. What is happening is that portacabins are being moved into some of the prisons. I was in contact with Littlehey prison yesterday and they have one of those portacabins. At the moment, 115 of their prisoners are not in

single-cell accommodation, so that will provide some space for them—I think about 24 spaces. In so far as there is headroom and there are a few more new units, it will be better, but I do not think it is going to solve the problem in the average local prison, for example, or in prisons that are quite crowded just now.

Q54 **Chair:** Ms Fooks-Bale, what have you gleaned from the CQC point of view and inspections on Marie's point?

Jan Fooks-Bale: Accommodation within prisons is outside our regulatory remit. We comment on it, because we jointly inspect and write the report, but it is not something we can enforce in any way.

Q55 **Chair:** Mr Clarke, is there anything from the inspectorate's end?

Peter Clarke: No, I do not think so. It is something that we are going to be looking at very closely when we start our visits to local prisons next week. It is obviously a key issue. As Dame Anne said, we are aware of efforts that are being made, but we do not as yet know through first-hand observation how successful those efforts have been.

Q56 **Kenny MacAskill:** I have a general question, first of all to Mr Clarke and then the others may care to jump in. What are the main issues affecting both the healthcare and social care of older prisoners?

Peter Clarke: In terms of a general question, Mr MacAskill, do you mean do I have a general observation?

Kenny MacAskill: Yes.

Peter Clarke: My general observation on both those subjects, which I think are intertwined, carries on from things I have said in the past. I am very sorry that there is not a coherent national strategy in respect of either the delivery of social care or the care of older prisoners. I have said before that I think there should be. I do not think the model for operational delivery approaches being a strategy. In fact, it specifically says that it is not intended to be a strategy. To my mind, it is a set of tactical options that are available to governors.

The slight contradiction is that the same document says that it is intended to support and inform the prison estate's transformation programme, which is designed to reform the prison estate into three categories of prison by 2023: reception, training and resettlement. No doubt that will be delayed because of current events.

If those tactical options are supposed to support and be informed by the reconfiguration of the prison estate, it sounds to me as if it is a strategy by any other name. But it is not, because, as one of the contributors from the earlier panel said, it is not obligatory. Although it says that provision for older prisoners should be designed to meet individual needs, as opposed to addressing them as one single cohort, my fear is that it falls between those two stalls and does not actually do either.

The same thing applies to social care. Two years ago, we worked with the CQC and did a joint thematic inspection of social care. We found

inconsistencies across the country. The main recommendation from that thematic inspection was that the Secretary of State should use his authority to draw together the various agencies involved in the delivery of social care in prison and try to ensure that there was consistency in its delivery. That recommendation was rejected on the basis that under the Care Act responsibility for delivery of social care sits with local authorities and it would not be appropriate for the Secretary of State to intervene.

Nevertheless, it seems to me again that there is a falling between two stools. If the model for operational delivery for older prisoners says that resettlement prisons should in the future be configured to meet social care needs, because those are the prisons from which older prisoners are likely to be released, that is not joined up in any way, as far as I can see, with the responsibilities of local authorities to deliver social care in their particular geographic area. Of course, local authorities have no remit or ability at all to influence the physical conditions in prisons on which so much of the effective delivery of social care depends.

Q57 **Kenny MacAskill:** My next question is on the follow-up to the thematic review you mentioned. Has there been any progress on that whatsoever?

Peter Clarke: Where prisons have developed memorandums of understanding with local authorities, yes, there has been some progress. Last year, of the 42 prisons we inspected, we found that 12 either had out-of-date memorandums of understanding or no MOU at all[1]. There is still a gap. There is a need to drive consistency. That is why I was particularly disappointed that the main recommendation—that central Government should use its influence to co-ordinate activity across the country—has not been accepted.

Q58 **Kenny MacAskill:** Do any of the other witnesses want to come in?

Jan Fooks-Bale: We are the regulator of adult social care inside prisons and in the wider community. I agree with Peter that we are still seeing unacceptable variations. Some of that is around the ability of local authorities to commission a provider of social care—a domiciliary care agency—to come in and provide it.

The model that seems to work better is one where the healthcare provider is also the social care provider, because it enables a bit more flexibility and a more holistic approach. We are still seeing quite a bit of variation, which we report on, and we take enforcement action where necessary. Unfortunately, we have no powers over local authorities, who are the commissioners of the service. I agree with Peter that, where you have joined-up working at a senior level, a memorandum of understanding and an established working partnership, it tends to result in better service delivery.

There continues to be quite a reliance on informal peer support. We see some really good practice where prisoners are trained to be buddies or

[1] Correction by the witness: 10 out of 42 prisons inspected in the 2019/20 year did not have a memorandum of understanding (MoU) with their local authority in relation to the delivery of social care or had an MoU that was out of date.

support their peers, not with personal care but with some of the other activities of daily living, such as collecting meals. We see some good schemes in place. Unfortunately, we are still seeing examples where the buddy system is in place but there isn't adequate oversight or training of those buddies, which obviously carries a risk, given the vulnerability of the people they are supporting.

Q59 **Chair:** What is it that makes the engagement of local authorities so variable?

Jan Fooks-Bale: That is a really good question.

Q60 **Ms Marie Rimmer:** Is it not the different ways of operating? In St Helens, where I live, we have a completely integrated health and social care model, and it is superb. We do not block beds.

Why can prisons not be linked with local authorities? We have a joint director of health and social care, with links in the community. They do not come out unless everything is set up—the home and everything. Before they go into hospital all their needs are met, and before they go out. Why can we not make it a duty within the prisons to link with the local authority, which then links with social care if they are separated? Most local authorities are doing some model of integration.

The DWP go into Liverpool prison for young people or people of working age so that they get trained and linked to training and employment. Why can we not have that for health and social care? Surely there is a duty of care somewhere.

Dr Benneyworth: I want to talk about some of the themes in the "Beyond barriers" report, in which we wrote about the integration of health and social care. That was about all health and social care systems. We found many barriers as to why health and social care did not work well together in those systems. There is a real opportunity, with the development of integrated care systems, to start to answer some of the questions about how we look at transfers in and out of prisons, and how we look at health and care systems working together to make sure that they are as smooth as possible, and develop local pathways to improve outcomes.

Q61 **Kenny MacAskill:** What is thought to be the most effective way of delivering that collaboration?

Dr Benneyworth: We see some good examples across the country of local collaboration, with integrated care systems and STPs, where the leadership of health and social care is working very collaboratively together. They are looking at setting common goals and developing shared pathways, and looking at some of the barriers that may get in the way of collaboration, such as the finances and other aspects.

We need to share that best practice and look at highlighting those really good exemplars, making sure that we can encourage all the other systems, where they have not quite got that level of maturity, to adopt some of the good ways of working that we are seeing.

Q62 **Kenny MacAskill:** Does Ms Fooks-Bale have a view on that at all?

Jan Fooks-Bale: If we are talking about the delivery of social care in prisons specifically, it works better where there are more older prisoners in the prison. Dame Anne alluded to that earlier. It almost seems to be easier to deliver because the prison is more focused on the needs of older people. We find more challenges in the busy local prisons, where there are fewer numbers who require social care support and, therefore, the prison is less focused on it. There is less engagement and the partnership is less robust.

Q63 **Kenny MacAskill:** I have two brief points for Mr Clarke. First, it was once raised with me by a former chief executive of the Scottish Prison Service that it would be easier to convert a care home to a semi-secure facility than it would be to convert secure facilities to a care home. Given the percentage and number of prisoners, is there any merit in considering that as a strategy?

The second point is whether restoring the rank of hospital officer should be considered, given the specialisation that now appears to be coming through.

Peter Clarke: I will concentrate on the first point about the type of accommodation. This is something that I have raised specifically in the past—whether there is a need for people in their 70s and 80s, who are not particularly fit and are possibly disabled or have other needs, to be held in category B and category C conditions of security. I do not deny for a moment that some of those people can still give a high risk of harm, but I have posed the question several times in the past as to whether we should be thinking about a different type of custody.

To put it crudely, it would be a care facility with a wall around it, where there is sufficient security to hold those people safely, securely and decently, while potentially giving a considerable amount of headroom within the more secure estate, where higher levels of security are needed. Unfortunately, the model for operational delivery, which we referred to earlier and which was published in April 2018, specifically excluded consideration of a different type of custody. To my mind, that was a missed opportunity. I think that is a shame.

I am afraid that the question of whether the grade or rank of hospital officer should be introduced is not something on which I can particularly comment, although I note that, in the context of caring for older prisoners, there is a degree of inconsistency in training in a number of areas. Some people working in healthcare in prisons are more aware than others of the particular needs of people potentially suffering from dementia or other conditions. There is inconsistency, and it plays into the whole issue of, "Do we need more consistency and strategic approach across our prison estate?"

Q64 **Dr Mullan:** I am interested in your comments, Peter. I understand that we are quite rightly talking about risk and health. How do you weigh up what the victims of crime would expect in terms of someone's need to

stay in a more stringent setting in prison? How does that get factored into all these decisions? It is not just whether they would be a risk if they escaped. We are talking about extremely serious sexual offences that some of those older people have committed. I am not sure that the public or the victims of crime would necessarily want those people to be in less stringent conditions just because they are older.

Peter Clarke: It depends what we mean by stringent. It is well accepted that the conditions in which you are held should not be part of the punishment. The punishment is the sentence of the court and relates to the length of time for which you are deprived of your liberty.

I am not suggesting for a moment that, whatever this type of alternative accommodation should be like, it should be some cosy place with soft furnishings and all the rest of it. What I am asking is whether there is a need for those people to be held in overcrowded higher security establishments such as the category B and category C prisons. Does it make sense to hold disabled people in conditions that are not suited to them?

HMP Dartmoor was built in the first decade of the 19th century. It was not designed to hold people with accessibility needs. The doors of the cells were simply designed for prisoners of war in 1804. They were not designed to accommodate people with walkers and wheelchairs, and those will not fit through them.

It is not about being soft or anything like that, but about having appropriate accommodation. They are still going to be deprived of their liberty. I am not suggesting for a moment that those people should all be let out—far from it. But they should be held in appropriate accommodation.

Q65 **Dr Mullan:** That is very helpful. I understand the theory. In your view, and from your experience of being in prisons, there would be nothing different about them, except for the security in which prisoners are held and their ability to escape. You do not think that prisoners in any way seek or prefer to be in lower category prisons because, in reality, there is a difference in the lived experience of a prisoner there.

Peter Clarke: Of course, there is. Many prisoners aspire to go to open prisons, category D prisons, because there are different and better conditions. I am not suggesting that. I am not suggesting either that this alternative type of accommodation for older prisoners would be exactly the same.

The whole point should be that it is part of a strategic approach to meeting needs—indeed, the model for operational delivery itself says that it should be about meeting individual needs, and those facilities could be better equipped to meet social care needs. You could have staff who are specifically trained in meeting those needs. They could be much more focused and meet the needs much better than many of our existing overcrowded, ill-equipped and, frankly, unsuitable local prisons.

Ms Marie Rimmer: Is there an opportunity to try one of the mobile units to house older prisoners? Could that be adapted better within the prison walls? It could be separate; it could be smaller. It is an opportunity that could perhaps be tried out somewhere.

Chair: Is anyone able to comment on that, or is it just a proposition?

Ms Marie Rimmer: I have never been in one, so I do not know what they are like, but they may be easier to adapt.

Chair: I do not know if any of our witnesses have either.

Q66 **Andy Slaughter:** I do not know whether our witnesses heard the discussion we had earlier with the first panel about dementia and palliative care. Essentially, the witnesses were saying that for those inside prison there is a rather hit-and-miss service and there is no consistency of approach. Neither is there a consistent approach in relation to release, particularly consideration of whether somebody can be released who is coming towards the end of their life and does not exhibit a risk.

Also, is there any particular merit in keeping somebody in prison at all if they are in the later stages of dementia and not particularly aware of their surroundings? I do not know whether you have experience of either of those two categories of people or what you think should be done.

Dr Benneyworth: I will start on end-of-life care and dementia. We have seen some improvements in end-of-life care over the last couple of years that are really promising, although there is still significant variation in what we see. End-of-life care and dementia are two areas that need good partnership working, with care co-ordination and people having the skills and training to be able to deliver good partnership working in those areas.

In dementia care, we see less consistency. We would like to see much more consistency in dementia care pathways to make sure that people get early identification, as Professor Shaw was saying earlier on, and making sure that when people are diagnosed with dementia they get good joined-up care to meet their health and social care needs.

When we inspect, we ask about compassionate release and whether it has been considered, but we would not want to comment on the policy aspects of that.

Q67 **Andy Slaughter:** What are the policy aspects of that? We have been told that release on compassionate grounds is very restricted and is unlikely. People have to be bedridden, incapacitated or have a clear terminal illness of around three months, but the assessment of risk may be based on the individual before they became vulnerable with dementia or terminal illness. I do not know whether Mr Clarke can comment on that at all.

Peter Clarke: My main observation about palliative care is that again, like so many of these issues, it is inconsistent across the estate. I have seen some very good dedicated palliative care facilities—for instance, at

Leyhill and the Isle of Wight. I have seen some sterling efforts being carried out in what can only be described as inadequate facilities, where prison managers have done their very best in sometimes very old facilities to provide palliative care for those who are coming near the end of life.

The other thing to bear in mind is that not every prisoner—I have come across a few—actually wants to leave prison at the end of their life. For many men getting towards the end of very long sentences—it is usually men—the people around them in the prison are their family. They are the people they relate to; they have nothing outside.

As Dame Anne mentioned earlier, if you are going to release somebody, you have to have somebody or somewhere to release them to. It is not unusual for older prisoners to say, "No, this is where I want to spend my last days." There has to be a degree of flexibility in care and compassion about that.

Dame Anne Owers: I agree with what Peter is saying. There is variable palliative care. In one prison, there is a palliative care unit set up that has never been used and so is now being used for something else. It varies quite considerably.

What also varies quite considerably is a prison's relationship with local hospices. That is obviously a source of good end-of-life care. Some have very good relationships and are able to move prisoners there at the appropriate time. It is something that is very variable.

Our boards say that the compassionate release scheme is very bureaucratic, very clunky and takes a long time. You have to look at the circumstances of the individual. As Peter said, and as I said earlier, some who have been in prison for decades, for example, would prefer to spend their last days in familiar surroundings, surrounded by people they know.

Q68 **Miss Dines:** I have three questions about prison accommodation. We touched on it slightly in terms of Dartmoor. How well in general do our prisons meet the accessibility needs of older prisoners who may have disabilities, due to their age or other reasons, and reduced mobility?

Chair: Peter, you mentioned something about Dartmoor.

Peter Clarke: There is a bit of a theme this afternoon. It is totally inconsistent. There are some places where they have made accessibility. For instance, at Stafford, which has quite an old population and some of the oldest buildings in the prison estate, going back to the late 18th century, the ground floor of one of the very large wings has had some adaptations made so that all the cells are accessible by wheelchairs. There are no steps. In many other prisons, that is not the case.

Usually local management, when they create units for older prisoners, try to put them on the ground floor, but that is not always possible. We come across cases where men are held in conditions that are completely unsuitable in terms of accessibility. It is a mixed picture. That is why I

say again and again, rather dully, that we need a strategic approach geared towards making sure that there is sufficient and appropriate accommodation for older prisoners.

Q69 **Miss Dines:** What processes are there when older prisoners are brought into the estate as to how they are allocated—where they go? What process is there, and do those processes actually work in your experience?

Chair: Jan, do you deal with that side of things?

Jan Fooks-Bale: We observe reception screening, which is the assessment by a nurse when somebody comes into prison. Nurses always complete a risk assessment around cell sharing and can make recommendations, but actually the placement of prisoners often comes down to security and the prison itself. We have no power to make recommendations, other than a joint recommendation with Her Majesty's inspectorate of prisons.

Q70 **Miss Dines:** What is your professional view? Are the processes that exist effective or not? What would be your view?

Jan Fooks-Bale: Peter is probably in a better position to comment on the placement of prisoners because it is outside CQC's remit. We do not necessarily have the information to go on.

Peter Clarke: I cannot comment on initial allocation because that is something that happens long before they get into the prison estate. What we have seen on occasions is failed transfers, where prisoners have been transferred from one establishment to another and, for whatever reason, the requirements either for accessibility or for social care have not been met. It is not unknown for prisoners to have to be sent back whence they came. That of course is unsatisfactory. I cannot comment on the initial allocation. That is something that happens well before HMIP become involved in looking at treatment and conditions.

Q71 **Miss Dines:** In your experience, Mr Clarke, are those failed transfers isolated cases or are there quite a few of them?

Peter Clarke: We do not see them that frequently, I am pleased to say. It is something that happens occasionally, but it is not what I would say is a regular feature of our findings on inspection.

Q72 **Miss Dines:** We have heard that some prisons have developed specialist wings for older and more vulnerable prisoners. How available are those? Are they very rare or are there quite a few of them?

Jan Fooks-Bale: We have seen examples where they work really well. In HMP Bure, HMP Norwich and the Isle of Wight there are specific wings, but unfortunately often the demand exceeds the capacity to provide that dedicated accommodation.

We have seen other areas where there is insufficient accommodation. Where a wing is set up, we tend to have staff who better understand the needs of that particular group and know them particularly well. Health

and social care is delivered on the wing, without the need to move people about the estate. They can work very well, but usually demand exceeds capacity.

Q73 **Miss Dines:** On balance, in summary, does segregation actually work, when you think of everything—their emotional needs and their need for social interaction? Does segregation work?

Dame Anne Owers: To be honest, it varies. As some of your earlier witnesses said, we have come across cases where older prisoners do not want to move on to a wing because, for example, it is associated with being a wing for men convicted of sexual offences, and they were not. Also, sometimes people prefer to be in an environment with younger people.

You have to deal with this on a case-by-case basis, but you have to make sure that there is sufficient provision for those who need particular care and that they are not put, for example, in some of the conditions that our boards have described. We talked about single cells earlier. A double cell with bunks is not acceptable for older prisoners. They cannot manage there.

Somewhere like the prison at Coldingley still has no in-cell sanitation and allows eight minutes for people to get to the toilet during the night. For older people, that may be quite a regular occurrence and they may not be able to manage it in eight minutes. We need to be clear that we are not holding older people in conditions that are clearly unacceptable in view of their age and physical or mental condition.

Q74 **Chair:** Are there any other comments on that?

Peter Clarke: To go back to the question about whether there are good examples of units, I can refer to one in particular that is good: Houseblock 14 at HMP Northumberland. I have been there. I have spoken to the older men. They find it a very peaceful and much more supportive environment. To be frank, some of them said to me that it was a relief to be off the main accommodation wings, away from the violence, the loud music and the drugs. They found a much more amenable atmosphere within that dedicated unit. I saw that while I was there. An elderly man had some difficulty with his mobility while he was queueing for lunch, and other prisoners came to his assistance and helped him, and so on and so forth.

That is an example, to my mind, of good practice, but whenever I go around the country and say to people, "Are you aware of what is happening in HMP Northumberland to look after older people?" the usual answer is no. There is something about capturing and spreading good practice, and understanding what can work.

To return to my earlier point, this is not about making a soft existence. It is still in a prison. There is no doubt about that at all. If anyone who goes into one of these units thinks it is some sort of soft option, that is not the

case. It is just about having a better environment for men who are being held in the later stages of their life.

Q75 **Dr Mullan:** We have looked at health and personal care needs primarily. In terms of the schemes that people have to undertake meaningful activity in prison, would you say that there is room for improvement in terms of activities that are likely to be of interest and productive for people of an older age?

Peter Clarke: That probably falls within my remit. Yes, there is a shortage of purposeful activity for older prisoners. One issue that we come across occasionally is that, when prisoners reach retirement age, they are forced to retire, and that is not necessarily the best thing for them. It means that very often they are locked up in their cell, as opposed to being out doing something else.

One of the more extreme examples we came across in recent times was an 88-year-old man who was only out of his cell for about two hours each day because there was simply nothing else for him to do. There is something about keeping some sort of meaningful activity going past retirement age, and appropriate activity as well.

Some prisons are very good at that, whether it is some sort of day centre, lighter work or indeed education. It is finding things that are appropriate to the population. The idea that once somebody is past 65 they should just be left to sit in their cell is not appropriate and is, I believe, counterproductive.

Q76 **Dr Mullan:** I assume that is not based on any legal requirement for people to stop working. It is not like police officers who sometimes have age requirements for retirement. It is just a decision that prisons are taking in relation to that age.

Peter Clarke: Yes, that is right.

Q77 **Chair:** Are there any other observations on those points?

Dr Benneyworth: We know that this population have long-term conditions and many health conditions. Exercise becomes even more important when you have long-term conditions, to improve outcome. It is important that people get the opportunity to be active for their health.

Q78 **Dr Mullan:** That question brings us to an issue we have touched on already. To what extent do all prisoners have an entitlement to physical activity, and how do we measure what everybody is entitled to versus special things being made available for one group?

Dame Anne Owers: There is a requirement for all prisoners to have exercise. It is part of the routine. Keeping healthy and keeping fit is necessary for all prisoners.

The point in relation to older prisoners is that they can get forgotten, because the kinds of exercise and stimulation, both mental and physical, that they need will be different from those for younger prisoners. It is a

question of making sure that that particular cohort is looked after. That is where I would very much go back to what Peter Clarke said almost at the beginning of your session. There is a need for a proper national strategy that links together all of these things—where you place prisoners, what kind of environment, and what you would expect. Your strategy should drive your operations rather than the other way round.

Q79 **Dr Mullan:** I understand that. My question back to you is not to challenge that. In principle, I agree with that, but it is how we weigh up the fact that, in a fixed community and in a fixed setting, there will be people wanting to do different types of exercise. Among the younger prisoners there will be different things that different people would see as suitable and right for them.

How do we weigh up the balance between affordability and use of space, which means that you cannot put on a different form of exercise for everybody, and what individuals might want as appropriate for them? I imagine that there are probably some simple and widely accepted forms of exercise that might be accessible and engaging for older people. That would be my instinct.

Dame Anne Owers: Yes, there are, and they are not particularly expensive. I take you back to what some of your earlier witnesses said. There could be much greater use of the voluntary sector in the kinds of activities that that age group needs, and assistance with seeking to provide them. We are not talking about hugely techy things. We are talking about things like carpet bowls and, potentially, wellbeing exercises, and so on. Those are not very expensive things to provide, but it means that you have to be able to look at what all of your population need and what will keep them well while they are with you.

Q80 **Chair:** Are there any other observations? Most people agree with Dame Anne's proposition.

Jan Fooks-Bale: We see some good partnership working between healthcare and gym staff. Age-specific gym sessions are put on for older prisoners in the male estate.

Q81 **Chair:** That is helpful.

We have talked quite a lot about a national strategy, which may be the last topic we are going to talk about. Peter, I remember, going back some time, that there was an MOJ steering group working on a national strategy for older prisoners. I think you told our Committee once in one of the previous Parliaments that you had been invited to it but that it met once and never seemed to meet again. Whatever happened to that?

Peter Clarke: Chair, that is a very good question. Whatever happened to that? I looked back through my diaries and calendars and found out that actually that steering group was held on 11 December 2017. I went to it. I was very heartened by the fact that, allegedly, it was set up to generate a strategy for older prisoners.

I was also heartened by the attendance. There were people from NGOs, from statutory bodies and from HMPPS; there was me and so on. I thought, "This is good." That was it. The next thing that happened was that the model for operational delivery, declaring itself not to be a strategy, was published the following April.

I think it was a missed opportunity. It is a shame. That is where we are at the moment, though.

Q82 **Chair:** Was there a Minister at the steering group or was it dealt with by officials?

Peter Clarke: It was dealt with by officials.

Q83 **Rob Butler:** I would like to pick up where you left off, Mr Clarke. We heard from our earlier witnesses that they are very keen to have a national strategy. As you say, there is this existing document that is 47 pages long and gives lots of operational guidance. What would you want there to be on top of that in a national strategy?

Peter Clarke: They would be the sorts of things that I would expect to see in any strategy. I would want some timelines. I would want to see some accountabilities. I would like to see some resourcing and some clear objectives about what the strategy is intended to achieve. You can hang all sorts of activity from that.

As it stands at the moment, the model for operational delivery is a menu of options. It is no more than that. They are exactly that: options. I would like to see something that aligns population projections, about the type, capabilities and needs of the future population, with the future residential estate in prisons. When you line the two up together, you can start resourcing it properly and decide what you actually want to deliver in operational terms.

Q84 **Rob Butler:** Do you have a view of what you think those objectives should be?

Peter Clarke: Yes. I do not mean to sound trite, but the inspectorate has a set of expectations around safety, respectful detention and so on. I would expect the operational estate to be safe, respectful, purposeful rehabilitative detention, in line with our expectations. That is not always possible at the moment for all cohorts of prisoner because they are not specifically catered for.

Dr Benneyworth: We would be very keen to have a national strategy as well, and fully support that. We would want to include how to look at our purpose as the CQC through that strategy, which is to make sure that people get safe, effective care that is accessible, caring, compassionate and meets people's needs.

Q85 **Rob Butler:** And you do not feel that that is catered for in the guidance in the existing model.

Dr Benneyworth: We would be keen to pull the different aspects together, as Peter said, to develop an overall strategy between the environment, health and care.

Dame Anne Owers: I completely agree. As I said earlier, I think your strategy should drive your operational model, rather than your operational model being the only show in town. I would want something that pulled everything together; that pulled together health and social care, where you place people and what your projections are for the future, and not just what you might do now if you can but what you ought to be planning for, given the way we know the prison population is going. A national strategy would be incredibly helpful.

I do not really buy the argument that people are different. Of course they are, but within your national strategy you cohort different people and you look at individual needs. All women are different, but that does not mean that we do not have a strategy for women's prisons. The strategy is really important in pulling everything together and trying to drive the care of older people in prison.

Q86 **Chair:** Does anyone have any pressing questions or any other answers?

Jan Fooks-Bale: I want to pick up Dame Anne's point about there being a female offender strategy. Across the female estate, we are currently talking about 4.5% of the total prison estate, whereas older prisoners make up in excess of 32% of the prison estate. That puts the case for having a strategy that sets priorities, sets the direction of travel and takes account of their particular vulnerabilities and needs.

Chair: That is very helpful. Thank you very much to all our witnesses for coming to give evidence to us today. Thank you to the Members. I am grateful to all my colleagues and to our support staff. Unless there is anything more that anybody wishes to raise, the session is concluded.