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Justice Committee

Ageing prison population

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Justice Committee

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Summary

Older prisoners are the fastest growing group in the prison population. The number of prisoners aged 60 or over has increased by 82% in the last decade and by 243% since 2002. This rise has primarily been driven by an increase in the number of older adults sentenced for sexual offences. In addition, increases to the length of sentences has meant that more people grow old in prison. It is likely that the older prisoner population will continue to increase. Though the Ministry of Justice's most recent prison population projections show the over-60 population remaining broadly stable over the next four years, these do not factor in key Government policies, such as increasing police numbers and sentencing reform.

An ageing prison population creates challenges for the prison system as older prisoners often have distinct needs. In particular, older prisoners carry a greater burden of health conditions compared to their younger peers. There is a greater prevalence of chronic diseases, disability, decreased mobility, and sensory impairment among the cohort. As many as 85% of prisoners over 60 may have some form of major illness. Though the needs of individuals vary, collectively, older prisoners therefore have a greater need for health and social care.

Many prisons, particularly those built in the Victorian era, were not designed to accommodate individuals with accessibility requirements. Often, therefore, older prisoners and others with disabilities or reduce mobility need reasonable adjustments to be made for them to receive equitable treatment within a prison. Our inquiry has found that the provision of reasonable adjustments is highly inconsistent across the prison estate and often constrained by limited funding.

Some prisons have developed activities and forums tailored to older prisoners. But at others a lack of age-appropriate activities and the limited physical accessibility of the estate can make it difficult for older prisoners to participate in the regime. Those who no longer or are unable to work in particular can spend extensive amounts of time confined to their cells. This negatively effects both their wellbeing and rehabilitation.

Given the greater health-related needs of the cohort, older prisoners are disproportionately impacted by problems in prison healthcare. A particular issue is the cancellation of external medical appointments due to shortages of staff to escort prisoners to hospital or surgeries. Awareness among prison staff of age-related health conditions, particularly dementia, and the availability of screening for such conditions, is not always sufficient. Holding individuals with severe dementia or other complex health and care needs on the prison estate is particularly challenging and we suggest that in some circumstances an alternative form of custody should be considered for these prisoners.

The rise in the number of older prisoners has primarily been driven by an increase in the number of older adults sentenced for sexual offences. The Committee recognises that a significant element of this cohort are convicted for historic sexual offences. Particular attention must be given to the feelings of victims of such cases, both because of the nature of the offending itself and because of delays often experienced in bringing

such perpetrators to justice. We recognise that some of those victims may consider that alternative custody arrangements and potential early release of some individuals risks adding to the suffering that they have already endured.

The ageing prison population has increased demand for social care. Despite improvements following the Care Act 2014 and equivalent Welsh legislation, standards of social care are highly inconsistent across the prison estate. There can be a lack of coordination between prisons, local authorities, and social care providers. A more strategic approach is needed for the provision of social care in prisons.

We welcome improvements in end-of-life and palliative care on the prison estate, though this has not been consistent. The ageing prison population means there is likely to be an increasing need for palliative and end-of-life care and it is important that HMPPS and individual prisons plan accordingly.

At some prisons, resettlement approaches are focused towards younger cohorts and do not consider the specific needs of older prisoners. In particular, older prisoners who have served long sentences and experience institutionalisation can require additional guidance and support before re-joining society. There can be challenges finding suitable post-release accommodation for those with disabilities, reduced mobility, or complex health conditions. Continuity of health and social care is not always well-coordinated among responsible organisations. We also note issues with older prisoners accessing prescription medication following their release and not being registered with a GP.

The greater needs of older prisoners and the challenges many prisons face in meeting these warrants a specific policy for the cohort. Though HM Prison and Probation Service has recently published operational guidance on managing older prisoners for prison governors, there needs to be an overarching, strategic approach. We therefore reaffirm the call of a previous Justice Committee for the Government to produce a national strategy for older prisoners.

1 Introduction

Background to the inquiry

1. The number of people over the age of 60 in prisons in England and Wales has increased significantly in the past two decades. The over-60 prison population rose by 243% between June 2002 (the point at which comparable records begin) and March 2020, from 1,511 to 5,176. The proportion of prisoners aged over 60 also increased during this period: from 2% to 6% of the prison population.[1] A previous Justice Committee inquiry, *Older Prisoners*, which concluded in 2013, examined the issues raised by an ageing prison population and identified multiple challenges that older prisoners can face. These included a physical environment and prison regime that, even with reasonable adjustments, are often difficult for them to access; barriers to appropriate health care; and a lack of social care provision. Problems were also found with the resettlement of older prisoners, including difficulties finding accommodation and problems with continuity of health and social care from prison into the community. Among other recommendations, the report advised that the Ministry of Justice (MoJ) produce a national strategy for older prisoners to provide for minimum standards that produce effective and equitable care.[2] The Government rejected this recommendation and no national strategy for older prisoners has been produced.[3]

2. In the years since that inquiry, the older prisoner population has continued to increase and there appears to have been little progress towards addressing many of the issues it highlighted. A 2019 Justice Committee inquiry, *Prison Population 2022*, identified many of the same problems, leading to the launch of this inquiry, with the following terms of reference:

- What are the characteristics of older prisoners, what type of offences are they in prison for and how is this demographic likely to change in the future?
- What challenges do older prisoners face, what services do they need and are there barriers to them accessing these?
- Is the design of accommodation for older prisoners appropriate and what could be done to improve this?
- How do older prisoners interact with the prison regime and what purposeful activity is available to them?
- Does the provision of health and social care, including mental health, meet the needs of older prisoners and how can services be made more effective?
- Do prisons, healthcare providers, local authorities and other organisations involved in the care of older prisoners collaborate effectively?
- Are the arrangements for the resettlement of older prisoners effective?

1 Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020; Ministry of Justice, Offender Management Statistics Quarterly: January to March 2019, accessed 25 May 2020

2 Justice Committee, Fifth Report of Session 2013–14, Older Prisoners, HC 89, 12 September 2013

3 Ministry of Justice, Government response to the Justice Committee's Fifth Report of Session 2013–14: Older Prisoners, Cm 8739, November 2013, page 16–17

- Does the treatment of older prisoners comply with equality legislation and human rights standards?
- Whether a national strategy for the treatment of older prisoners should be established; and if so what it should contain?

3. Nearly 40 written submissions were received before the 2019 general election, but time did not permit any oral evidence sessions. We have held two such sessions since deciding to resume the inquiry and are grateful to all those individuals and organisations who provided evidence.

2 The Older Prisoner Cohort

Defining the older prisoner

4. There is no universally accepted definition of old age in prisons. Age thresholds used by different organisations vary widely, from 45 to over 70.[4] In England and Wales, the age of 50 has been adopted by Her Majesty's Prison and Probation Service (HMPPS), in so far as the age of prisoners is recognised for operational purposes.[5] This age threshold was also used in most evidence we received. It is lower than what is usually considered old age in the general population. Several submissions explained that this definition of old age in prisons is based on evidence that the health-related needs of prisoners are advanced by around 10 years, relative to people in the general population.[6] For example, a 50-year-old prisoner could have the healthcare needs typically associated with a 60-year-old person in the community.[7] There is also research evidence showing that health and care needs of prisoners aged 50–59 are very similar to those in their 60s, suggesting that it is appropriate to include the former age group within the older prisoner cohort.[8] The accelerated ageing process may be caused by both lifestyle choices and social deprivation affecting a prisoner prior to custody, and by the effects of incarceration itself.[9]

5. However, the idea of accelerated ageing is not universally accepted.[10] It is also possible that access to healthcare within prison may reduce its extent.[11] The MoJ pointed out that rates of biological ageing and associated deterioration of health vary significantly among older prisoners, meaning, for example, that someone aged 70 may be healthier than another prisoner in their fifties.[12] As discussed later in this chapter, a growing number of older prisoners are individuals who have been sentenced to prison for the first time later in life. These individuals may well enter the prison system in better health than younger inmates who have already spent an extended period of time in custody. Consequently, the care and support required by individual older prisoners are not all the same. On this basis, both the MoJ and Association of Directors of Adult Social Services (ADASS) suggested that consideration of whether a prisoner was 'old' and required different management within custody should be based on an assessment of individual needs, rather than chronological age.[13]

4 Helen Codd, "Ageing in Prison", in Sue Westwood (ed.), *Ageing, Diversity and Equality, Social Justice Perspectives* (London, 2018), p 345–346
5 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
6 Age UK (AGE0025); Association of Directors of Adult Social Services (ADASS) (AGE0024); Care Quality Commission (AGE0038); Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England an (AGE0036)
7 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
8 Q2
9 Care Quality Commission (AGE0038)
10 Q2
11 Helen Codd, "Ageing in Prison", in Sue Westwood (ed.), *Ageing, Diversity and Equality, Social Justice Perspectives* (London, 2018), p 346
12 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
13 Association of Directors of Adult Social Services (ADASS) (AGE0024); Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England an (AGE0036)

6. In practice, prison authorities apply some flexibility around a prisoners chronological age and take individual needs into account. For example, Graham Beck, Governor of HMP Wymott, explained to us how:

> We are told that everybody over 50 in our custody is defined as an older person, so we make sure that we have appropriate assessments in place for everybody coming in, through our reception and induction processes, to focus on their needs, specifically if they are over 50. In practice, that means we have some flexibility in our regime. There are some men who are 50 and are happy to continue working and living in normal prison accommodation. Equally, we have some men who are younger than 50 but have specific needs around disability and other aspects of care—for example, social care. Although 50 is the absolute cut-off, we operate with some flexibility around individual needs.[14]

7. Our predecessor Committee, in its 2013 report on older prisoners, concluded that it did not make sense to impose a rigid classification of age when defining the older prisoner. However, they also argued that it was still important to identify common features among the cohort to inform policy towards older prisoners and address the ageing prison population.[15]

8. **A clear definition of the older prisoner is necessary for establishing a more strategic approach to the cohort and the ageing prison population. We do not take a view on what that definition should be, but whatever age threshold is used should be based on firm evidence, and we encourage the MoJ to keep definitions used under review. Flexibility is also important, so that frail and vulnerable prisoners younger than any age threshold–50, 60, or otherwise—are managed in the most appropriate way. We also believe that prisoners need as far as is possible to be treated as individuals and receive regimes that are tailored accordingly.**

The characteristics of older prisoners

9. Older prisoners can have distinct characteristics and needs compared to those of the wider prison population, including in relation to the nature of their offences, health needs, and behaviour. We give an overview of these below.

Offence profiles

10. Evidence we received for this inquiry and in the wider literature suggests that older prisoners can be split into four main criminological profiles:

i) Repeat or chronic offenders, who move in and out of prison for less serious offences and have returned to prison at an older age.

ii) Prisoners who have grown old in prison after receiving a long sentence earlier in life.

iii) Prisoners sentenced for the first time later in life for a short sentence.

14 Q101

15 Justice Committee, Fifth Report of Session 2013–14, Older Prisoners, HC 89, 12 September 2013, para 27 and 135

iv) Prisoners sentenced for the first time later in life for a long sentence.[16]

11. Increases in convictions for sexual offences in recent years mean that older prisoners increasingly fall into the fourth category.[17] 45% of men imprisoned aged 50 or over are serving sentences for sexual offences, including historic offences; for those aged over 70, the figure is around 80%.[18] This reflects that older adults are more likely to be convicted for sexual offences than their younger counterparts.[19] Within the prison population as a whole, around 18% of prisoners are serving sentences for sexual offences, demonstrating how older prisoners are more prevalent within this offence group.[20]

12. The next highest offence category among prisoners aged over 50 is violence against the person (23%) followed by drug offences (9%).[21] Most men within this cohort are serving long sentences, with around 48% serving determinate sentences of over four years and some 18% serving indeterminate sentences.[22] Among older female prisoners, sentencing profiles are more mixed; only around 4% of the female prison population are serving sentences for sexual offences.[23]

13. Older prisoners are less likely to reoffend than is the case among younger age groups. According to HMPPS's MOD: Older Prisoners, 10% of prisoners aged over 50 are assessed as posing a high risk of reoffending, compared to 59% of those aged 21–49 and 58% of 18–20 year olds.[24] Prisoners aged 50 or over are also less likely to commit further serious offences: 10% compared with 39% for 21–49 year olds and 71% for 18–20 year olds.[25] Proven reoffending statistics show that 17% of offenders aged 50 or more reoffend within a year of release; for all offenders the figure is around 29%.[26]

14. However, around 26% of older prisoners are assessed as likely to have a reconviction for an offence involving sexual contact within two years of release, compared to 18% of those aged 21–49 and 14% of those aged 18–20.[27] Research conducted by G4S in the prisons it manages has also shown that, while risk of serious harm and reconviction decreases with age for prisoners overall, the risk of serious harm, specifically towards children, increases with age among those convicted of sexual offences. This was attributed to increases in the number of historic sexual offenders entering prison for the first time at an older age.[28]

16 G4S (AGE0037); Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 4
17 G4S (AGE0037)
18 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
19 Offender Health Research Network, University of Manchester (AGE0030)
20 G4S (AGE0037)
21 Clinks and RECOOP (AGE0018)
22 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
23 Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020
24 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
25 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
26 Ministry of Justice, Proven reoffending statistics: January to March 2018, accessed 25 May 2020
27 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
28 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)

Health profiles

15. As a cohort, older prisoners experience high rates of physical and mental health problems and disability. Up to 90% of prisoners aged 50 or over have at least one moderate or severe health condition, and over 50% have three or more.[29] Among prisoners aged 60 or over, rates of major illness may be as high as 85%.[30] The prevalence of medical problems is greater in the older prison population than among younger prisoners.[31] For example, in findings from the Government's Surveying Prisoner Crime Reduction survey (SPCR), 70% of older prisoners said they had received treatment or counselling for a physical or mental health problem in the 12 months prior to custody, compared to 45% of prisoners aged under 50. Differences were mainly driven by physical health problems: 51% of older prisoners reported receiving treatment for this type of problem, compared to 27% of younger prisoners.[32] In addition, it was estimated that 54% of older prisoners had a disability (the figure for adults over state pension age is 45%), compared with 32% among younger prisoners (16% among working-aged adults more widely).[33] Of the 54% of older prisoners with a disability, 28% were estimated to have some form of physical disability, 15% anxiety and depression, and 11% both.[34] Regarding mental health, according to the British Association for Counselling and Psychotherapy, around 5% of prisoners aged 55 or over are estimated to be affected by dementia, while more than half of all elderly prisoners present with a mental illness.[35] This is broadly comparable to rates of mental illness among older adults in the general population.

16. As a consequence of the greater prevalence of health issues and disability among the cohort, the health and social care needs of the older prisoner population are more extensive and complex than those of younger prisoners. According to the MOD: Older Prisoners the average older prisoner has six separate health or social care needs.[36] The additional demands placed on prison health and social care is one of the major challenges created by an ageing prison population. The healthcare and social care of older prisoners will be examined fully in Chapter 5 of this report.

Backgrounds and behaviour

17. Evidence suggested that some aspects of older prisoners' backgrounds and behaviour can differ from that associated with younger age groups, which may lead to them having different needs from the prison regime. For example, the Government's SPCR survey found that older prisoners were more likely to report having higher qualifications, with around 17% of older prisoners reporting having a degree or diploma equivalent compared to 6% of younger prisoners. Older prisoners were also four times (12%) as likely to have reported

29 Criminal Justice Alliance (AGE0020)
30 Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 5
31 BMA (AGE0033)
32 Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 5
33 Gov.UK, 'Official Statistics, Disability facts and figures', accessed 13 July 2020
34 Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 5
35 British Association for Counselling and Psychotherapy (AGE0011)
36 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)

completing an apprenticeship as younger prisoners (3%).[37] The survey also found the older prisoners were less likely to report needing help with work-related skills or finding a job after release, though these findings may also have reflected that some older prisoners are near or over retirement age.[38]

18. Some evidence suggested that drug abuse is generally lower among older prisoners than in the prison population as a whole.[39] This also emerged in the SPCR survey, for which 28% of older prisoners reported drug use before custody compared to 82% of prisoners under 50. However, drug abuse in prisons has risen in recent years,[40] and Serco noted that they are starting to see a trend of increased drug and alcohol dependency among older prisoners.[41]

The ageing prison population

19. According to the MoJ's most recent quarterly statistics, there were 5,176 people aged over 60 in prison in England and Wales, as of 31 March 2020.[42] A further 8,588 prisoners were aged 50–59. These represent 6% and 10% of the prison population, respectively, which was 82,990 as of the same period. 1,790 prisoners were aged 70 or over. As of December 2016, 234 prisoners were aged 80 or over, with 14 in their 90s.[43] Joint inspections by the Care Quality Commission and HM Chief Inspect of Prisons since 2015 have identified 15 prisons where 30% or more of the population are aged 50 or over. In four of these, 10% of prisoners were aged 70 or over.[44]

37 Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 6

38 Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 7

39 Offender Health Research Network, University of Manchester (AGE0030); Women in Prison (AGE0027)

40 HM Prison and Probation Service, Prison drugs strategy (2019) p 3

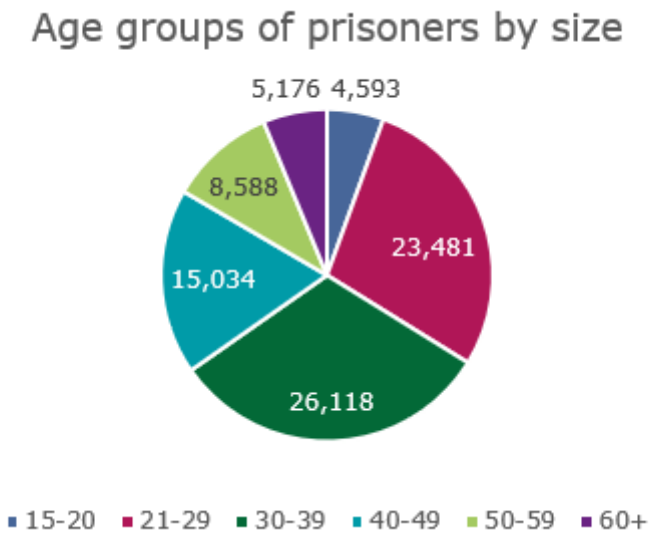
41 Serco Ltd (AGE0028)

42 Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020
During the Covid-19 pandemic, the prison population in England and Wales fell substantially, from 82,990 as at 31 March to 79,605 as at 19 June (according to official MoJ Statistics). It is unclear at this stage what effect the lockdown has had on the older prison population specifically. As such, this section uses figures from just before the start of the pandemic.

43 Offender Health Research Network, University of Manchester (AGE0030)

44 Care Quality Commission (AGE0038)

Figure 1: Different age groups of prisoners by numerical size



Source: Ministry of Justice, Offender Management Statistics Quarterly, March 2020

Notes: age groups combined

20. The older prison population has increased substantially over the last two decades. Between June 2002 (the point at which comparable records begin) and March 2020, the number of prisoners aged 60 and over increased by 243%, from 1,511 to 5,176.[45] For the 50–59 age group, the increase was by 159%, from 3,313 to 8,588.[46] The proportion of older prisoners has also increased: for those over 60, from 2% of the prison population in 2002 to 6% in 2020; and for those aged 50–59, from 4.5% to 10% in the same timeframe.[47]

21. This increase in the number of older prisoners has applied to both the male and female prison estates, though the size of the older female population is much smaller. The number of women aged 60 or over rose from 23 in 2002 to 131 in March 2020.[48] The 50–59 age group also increased in number, from 155 to 409 in the same timeframe.[49] The overall female population reduced by 18% in this period, from 4,394 to 3,623.[50]

45 Ministry of Justice, Offender Management Statistics Quarterly: January to March 2019, accessed 25 May 2020; Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020

46 Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020; Ministry of Justice, Offender Management Statistics Quarterly: July to September 2019, accessed 25 May 2020

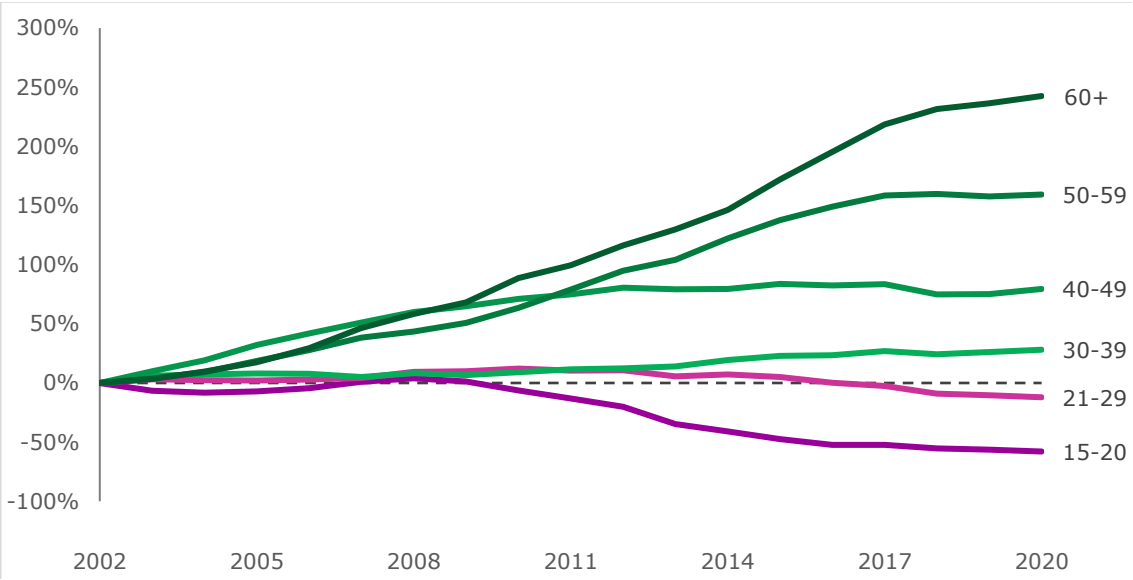
47 Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020; Ministry of Justice, Offender Management Statistics Quarterly: July to September 2019, accessed 25 May 2020

48 Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020; Ministry of Justice, Offender Management Statistics Quarterly: July to September 2019, accessed 25 May 2020

49 Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020; Ministry of Justice, Offender Management Statistics Quarterly: July to September 2019, accessed 25 May 2020

50 Ministry of Justice, Offender Management Statistics Quarterly: October to December 2019, accessed 25 May 2020; Ministry of Justice, Offender Management Statistics Quarterly: July to September 2019, accessed 25 May 2020

Figure 2: Percentage change in prison population by age category, England and Wales



Sources: Ministry of Justice, Offender Management Statistics Quarterly, various years

Notes: Data at June 2002–2019 and March 2020; age groups combined

Why has the older prisoner population increased?

22. The increase of the older prisoner population has primarily been driven by a rise in the number of convictions for sexual offences.[51] The number of prisoners serving sentences for these offences has risen substantially in the last two decades. There were 5,294 prisoners under immediate custodial sentence for sexual offences in 2002; by June 2019, it had risen to 13,196.[52] As mentioned previously, older adults are more likely to be convicted for sexual offences than their younger counterparts and older prisoners are disproportionately represented among this offence group within the prison population.

23. Sentence inflation was also identified as a cause of the ageing prison population.[53] According to the Prison Reform Trust, more than three times as many people were sentenced to 10 years or more in the 12 months to June 2019 than in the same period as 2007. For more serious indictable offences, the average prison sentence is now 57.7 months, which is more than two years longer than in 2007.[54] Average sentence lengths for sexual offences have increased in particular; given the high proportion of older prisoners convicted for sexual offences, this may have had a strong effect on the ageing of the prison population. According to the Howard League for Penal Reform:

> Sentences for sexual offences have increased dramatically—the average sentence length for sexual offences increased to 61.4 months (more than five years) in 2018—16.9 months longer than a decade ago.[55]

51 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)

52 Ministry of Justice, Offender Management Statistics Quarterly: January to March 2019, accessed 25 May 2020

53 The Howard League for Penal Reform (AGE0013)

54 Prison Reform Trust, Bromley Briefings Prison Factfile Winter 2019, accessed 26 May 2020

55 The Howard League for Penal Reform (AGE0013)

24. This increase in the length of sentences, as well as the continued incarceration of some prisoners on indeterminate sentences, has meant that increasing numbers of middle-aged prisoners entering custody grow old while in prison.[56]

Future projections of the older prisoner population

25. The MoJ's most recent prison population projection figures estimate that the population of offenders aged 60 or over will remain broadly constant between 2019 and 2023, both in absolute terms and as a proportion of the overall prison population. The population of offenders aged 50–59 is estimated to decrease by around 11%.[57] This predicted decline derives primarily from decreases in the number of people serving indeterminate sentences and a recent fall in the number of convictions for sexual offences.[58]

Table 1: Prison population aged over 50, 60 and 70 years old, June 2019 actuals and projected June 2020 to June 2023

	Total prison population	50 to 59	60 to 69	70 and over
June 2019	82,676	8,532	3,321	1,756
June 2020	82,300	8,100	3,200	1,800
June 2021	81,200	7,900	3,100	1,700
June 2022	81,400	7,700	3,100	1,800
June 2023	81,700	7,600	3,100	1,800

Source: Ministry of Justice, Prison Population Projections 2019 to 2024, England and Wales, August 2019, page 11

26. However, these projections do not factor in the potential effects of proposed Government policies.[59] In October 2019, the Government confirmed plans to recruit an additional 20,000 police officers over the next three years. Funding was announced to support the recruitment of the first wave of up to 6,000.[60] It is possible that an increase in the number of police will lead to increased charge rates and more people being sent to prison. The degree to which this occurs will depend on whether, and if so by how much, the average number of charges per police officer (currently 3.3 per year) rises.[61] In oral evidence, Justice Minister Lucy Frazer acknowledged that the older prison population was likely to rise with an increase in police numbers:

> What we are anticipating is that the population as a whole will increase, and it is likely that the elderly population will increase comparatively with the population as a whole, but it will not increase out of step with the population as a whole.[62]

27. In addition, the Sentencing Bill, outlined in the December 2019 Queen's Speech, proposes to change the automatic release point from half way to the two-thirds point for

56 Serco Ltd (AGE0028)
57 Ministry of Justice, Prison Population Projections 2019 to 2024, England and Wales (August 2019), p 11
58 Ministry of Justice, Prison Population Projections 2019 to 2024, England and Wales (August 2019), p 11
59 Ministry of Justice, Prison Population Projections 2019 to 2024, England and Wales, (August 2019), p 7
60 Home Office, "Home Office announces first wave of 20,000 police officer uplift", accessed 26 May 2020
61 Institute for Government, The Criminal Justice System: How government reforms and coronavirus will affect policing, courts and prisons (April 2020), p 16
62 Q146 [Lucy Frazer]

adult offenders sentenced for serious violent or sexual offences.[63] This may well lead to an increase in the number of such offenders in prison. Draft secondary legislation changing the automatic release point to two-thirds of the sentence for offenders convicted of a relevant sexual offence for which the maximum penalty is life and sentenced to a standard determinate sentence of seven years or more, was laid before Parliament in October 2019.[64] Justice Secretary Robert Buckland stated that the MoJ estimated that this would result in an additional 2,000 people being in prison by March 2030.[65]

28. **At the very least, older prisoners will remain a significant proportion of the prison population. It is likely that the size of the cohort will rise further after increases in police numbers and changes to sentencing come into effect. It is important that the size of the older prisoner population can be predicted as accurately as possible, so the prison system can prepare and be resourced most appropriately.** ***In its response to this report, the Government should publish updated projections for the ageing prison population for the next five years. These should factor in, as far as possible, the effects of its planned increases to police numbers and changes to sentencing policy.***

63 Prime Minister's Office, 10 Downing Street, The Queen's Speech December 2019: background briefing notes (December 2019), p 66

64 Draft Release of Prisoners (Alteration of Relevant Proportion of Sentence) Order 2019

65 Oral evidence taken of 16 October 2019, HC (2019) 41, Q16

3 Accommodation for older prisoners

The prison estate

29. As discussed in the previous chapter, rates of disability are high among older prisoners: it has been estimated that 54% have a disability, with 28% having some form of physical disability.[66] Reduced mobility is also common among the cohort.[67] Age and disability are protected characteristics under the Equality Act 2010. Section 20 of the Act imposes a duty on public-service bodies, including prisons, to make adjustments for disabled persons and prevent them being substantially disadvantaged by any provision, criteria or practice.[68] Prisons are required to ensure the equitable treatment of disabled prisoners under HMPPS policy, set out in Prison Service Instruction (PSI) 32/2011.[69]

30. The standard design of many prisons can restrict accessibility for prisoners with disabilities, those who have reduced mobility, or sensory or cognitive decline.[70] In particular, older establishments built during the Victorian era (about a third of the prison estate),[71] were designed for young, able-bodied men and women and without consideration for those with accessibility requirements. Even in fairly modern buildings, adaptations are often required in order to meet the needs of older prisoners, as G4S explained:

> Residential units across our establishments have a generic, modern prison design with galleried wings contributing to the majority of our accommodation. Without modification, units such as these do not fully meet the needs of older prisoners as few provide step free access to key facilities such as medication hatches, showers (when not cellular) and multi-purpose rooms.[72]

31. Without provision of reasonable adjustments, it can be difficult for older prisoners to receive care and participate in the prison regime. Adjustments may include grab rails in cells and bathroom facilities; lifts, ramps, and other means of providing step-free access to and within prison buildings; wheelchair-accessible cells; and mobility scooters or other walking aids, particularly on large prison establishments.[73] Evidence received for this inquiry indicates that the provision of adjustments and physical adaptations to meet the needs of disabled or less mobile prisoners is variable across the prison estate. We heard of good practice, particularly in prisons which have a substantial number of older prisoners.[74] However, elsewhere, necessary modifications are lacking; or, where facilities such as lifts are installed, faulty or out of use, with significant delays for repairs.[75] HM Inspectorate of Prisons described how:

66 Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 5
67 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
68 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
69 Serco Ltd (AGE0028)
70 Age UK (AGE0025)
71 *The prison estate*, Briefing paper number 05646, House of Commons Library, 28 November 2019, page 17
72 G4S (AGE0037)
73 Independent Monitoring Boards (AGE0034)
74 HM Inspector of Prisons (AGE0039); Catholic Bishops' Conference (AGE0004)
75 Independent Monitoring Boards (AGE0034); Prison Reform Trust (AGE0021)

> We found physical barriers to accessing communal areas at some prisons. For example, the health care department at North Sea Camp was a significant walk up a steep slope. At Dartmoor, the education department and chapel could only be accessed by steps, as was also the case for the exercise yard on F wing (which housed men with mobility problems). Some establishments had installed lifts and stairlifts but we found that these were not always working, as was the case at Swaleside. At Littlehey we found lifts were frequently out of order in 2015, and the situation had not improved by 2019, affecting those wishing to visit the chapel and healthcare unit.[76]

32. In-cell reasonable adjustments, such as grab rails and raised toilet seats are reportedly lacking in some prisons.[77] Problems also exist around older prisoners placed in cells without sanitation. At night, they must either ring a bell and queue to access the toilet or use a pot in their cell. This disproportionately affects older prisoners as their need for night-time access to sanitation is more likely and more frequent.[78] In addition, overcrowding on the prison estate means that older prisoners often share cells with other prisoners. This can be problematic, as the bunk beds used in shared cells are difficult to access for those with limited mobility. For example, a serving prisoner described to us how:

> I am not supposed to be in a top bunk because of mobility problems and severe COPD, but I have had to share a cell with a prisoner much less mobile and so I had to use the top bunk. Changing the sheets of a top bunk bed was a particularly perilous task whereby I had to perch on a chair feeling very unsafe and at high risk of a fall which at my age could have been very serious.[79]

33. Shortages of appropriate cells has led to prisoners with accessibility needs being housed in healthcare units in some prisons.[80] This can isolate such prisoners from the wider regime and reduce the number of places in healthcare available for prisoners with medical need.[81]

34. The MoJ stated that accessibility audits have been carried out at several prisons, with more planned, to identify access issues that require action.[82] They acknowledged, however, that ability of prison governors to implement physical adaptations is limited by the amount of capital funding available.[83] HMPPS has a significant backlog of major capital works, estimated to cost £916 million as at November 2019, with more than 60,000 outstanding maintenance jobs as at April of the same year.[84] It has estimated that it needs to spend £194 million annually on maintenance in the public prison estate for each of the

76 HM Inspector of Prisons (AGE0039)
77 Independent Monitoring Boards (AGE0034)
78 Independent Monitoring Boards (AGE0034)
79 A serving prisoner (AGE0022)
80 Prison Reform Trust (AGE0021)
81 Care Quality Commission (AGE0038)
82 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
83 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
84 National Audit Office, Improving the Prison Estate, February 2020

next 25 years.[85] In oral evidence, Justice Minister Lucy Frazer highlighted that the MoJ had secured an additional £156 million for maintenance funding for 2020–21, and would look to make further bids to address the backlog in the next spending round.[86]

35. However, some submissions pointed out that necessary physical modifications cannot be made at some prisons as the level of work required is too extensive to be accommodated by the building design or too disruptive for the prison regime.[87] Previous Government plans to close some old prisons in a poor state of repair have been put on hold; in October 2019 Justice Secretary Robert Buckland told the previous Justice Committee that he did not intend to close any prisons in the near future.[88] Lucy Frazer later confirmed that Victorian prisons would need to be kept open to house the expected number of prisoners.[89]

36. The previous Committee was told that the MoJ was developing a long-term estate strategy to address the maintenance backlog and the poor state of repair of many prisons. This would include surveying the estate to improve information on assets and their condition, to enable better decision making and prioritisation of maintenance projects.[90] In its response to our predecessor Committee's report on prison governance, the Government said it would publish the estates strategy by the end of 2020.[91]

37. The MoJ has also highlighted plans to expand the prison estate. In August 2019, the Government announced that it would create an additional 10,000 prison places, at a cost of up to £2.5 billion.[92] This would be in addition to an extra 3,500 places to be created as part of the Prison Estate Transformation Programme (PETP) announced by the then Government in 2016.[93] As at January 2020, 206 places had been built though the PETP.[94] In the Government's written submission to this inquiry, the MoJ said that the new build resettlement prisons at Glen Parva and Wellingborough already under construction as part of the PETP will feature design improvements to better accommodate older prisoners. These include level access across the site and the provision of lifts in all buildings, as well as cells appropriate for prisoners with reduced mobility. Consideration of the needs of older prisoners would also be included in the design of future new build prisons.[95] Lucy Frazer reaffirmed this in oral evidence,[96] and told us that the expansion of the prison estate would remain a priority for the MoJ despite the economic difficulties created by the Covid-19 pandemic:

> The Ministry of Justice, during the covid crisis, has looked at what work we need to continue as significant, important work to the Department. Our

85 National Audit Office, Improving the Prison Estate, February 2020, p.7
86 Q158
87 Association of Directors of Adult Social Services (ADASS) (AGE0024); Care Quality Commission (AGE0038); Serco Ltd (AGE0028)
88 Oral evidence taken on 16 October 2019, HC (2019) 41, Q44
89 Oral evidence taken on 22 October 2019 HC (2019) 42, Q24
90 Justice Committee, Prison Population 2022: Planning for the future: Government response to the Committee's Sixteenth Report of 2017–19, HC 2308, 11 June 2019, p 5–6
91 Justice Committee, First Special Report of Session 2019–2021, Prison Governance: Government Response to the Committee's First Report of Session 2019, HC 150, p 3
92 Ministry of Justice, "10,000 extra prison places to keep the public safe", accessed 4 June 2020
93 *The prison estate*, Briefing paper number 05646, House of Commons Library, 28 November 2019, page 15
94 National Audit Office, Improving the Prison Estate, February 2020
95 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
96 Q156

> building programme is our top priority, and we have continued to do site visits and investigate additional accommodation where we have existing sites.[97]

38. **It is welcome that the new prison places planned as part of the Government's expansion of the estate will be designed to better accommodate older prisoners and others with disabilities or limited mobility. However, the number of new places delivered under existing expansion projects has been limited. In addition, much of the existing prison estate is unsuited to the needs of older prisoners, and there is a substantial backlog of maintenance works.** ***We recommend that the long-term prison estate strategy in development specifically addresses the provision of reasonable adjustments and physical adaptations necessary to meeting the needs of the ageing population in existing prisons. In its response to this report, the Government should also update the Committee on the timeframe for publishing the long-term estate strategy in light of the Covid-19 pandemic, especially given the greater propensity of older people to contract the disease.***

39. **We are concerned that HMPPS is not consistently fulfilling its duties towards older and disabled prisoners, as required by the Equality Act 2010. These prisoners should not be housed in establishments where the physical design prevents them receiving equitable treatment.** ***In its response to this report, the Government should set out what processes are in place to ensure that older and disabled prisoners are accommodated in an appropriate setting.***

Specific accommodation for older prisoners

40. Some prisons have developed wings or units for older prisoners and others with complex care needs, typically located on ground floor level to improve accessibility. According to ADASS:

> These include some adapted cells that allow for wheelchairs and lifting equipment to be deployed and beds to be located so that, where required, two carers can safely work together on either side of an individual and therefore reduce the risk of injury to either the individual or themselves. Such units also offer the potential to install raised toilets and showers where an individual can sit and be supported to wash themselves with dignity and can facilitate a quieter, gentler regime that the individual may find less distressing.[98]

41. HMIP reported that such wings or units had been developed in several prisons where older prisoners make up 20% or more of the population.[99] The criteria for which prisoners are housed in this type of accommodation vary; for example, at HMP Usk, the older prisoner unit in development is for prisoners aged 67 and over, as well as prisoners with specific social care and other needs.[100] At HMP Frankland, a wing has been designated for prisoners over 55 years old.[101]

97 Q157
98 Association of Directors of Adult Social Services (ADASS) (AGE0024)
99 HM Inspector of Prisons (AGE0039)
100 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
101 HM Inspector of Prisons (AGE0039)

42. It was suggested that while these wings or units are more suitable for some individuals, not all older prisoners want to be housed on them. Some prefer to remain in an environment where they can interact with younger prisoners. In addition, other prisoners can associate age-specific accommodation with men convicted for sexual offences, leading to abuse for the residents of such units.[102] Dame Anne Owers, National Chair of IMBs, therefore highlighted the need to manage the question of whether to separate older prisoners within a prison case by case.[103] Adapting existing prison facilities to make them more accessible and age-friendly can be costly and disruptive.[104]

43. We received evidence suggesting that a different form of custody should be considered for very elderly prisoners, particularly those with disabilities or complex health or care needs. It is difficult and potentially costly to house such individuals appropriately on the secure estate, and the health of these prisoners means they may carry a lower risk of escape or harm.[105] Alternative accommodation could involve lower security and be focused on specific needs of elderly prisoners.[106] Peter Clarke, HM Chief Inspector of Prisons, summarised what this form of accommodation could look like:

> 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.[107]

44. Prisons Minister Lucy Frazer drew attention to how new prisons planned or under construction will be designed to better accommodate older and more vulnerable prisoners.[108] HMPPS's Model for Operational Delivery: Older Prisoners, states that there are no plans to separate older prisoners through specific accommodation strategy.[109]

45. **It can be very difficult to accommodate some older individuals on the prison estate. Steps taken by some prisons to develop specific wings or units for older prisoners are welcome, though the variability of individual needs should be considered. *Good practice around the accommodation of older prisoners should be shared more widely. We recommend that all prisons housing a significant number of older prisoners designate appropriate accommodation for those with more complex health and care needs. We further recommend that the Ministry use the expansion of the prison estate to develop additional accommodation that is specifically adapted for older prisoners. The viability and cost of developing bespoke forms of custody for those with disabilities or nearing the end of their lives should also be explored.***

102 Independent Monitoring Boards (AGE0034)
103 Q73
104 Serco Ltd (AGE0028)
105 BMA (AGE0033); NOTA (National Organisation for the Treatment of Abuse) (AGE0012)
106 NOTA (National Organisation for the Treatment of Abuse) (AGE0012)
107 Q63 [Peter Clarke]
108 Q156
109 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)

4 Regimes and activity for older prisoners

46. All prisoners are meant to have sufficient time out of their cells and be able to engage in appropriate activities which support their rehabilitation. However, older prisoners can face challenges to participating in the standard prison regime. Disability, reduced mobility, or health problems can mean it takes longer and be more difficult for them to access different parts of a prison.[110] The design of some prison buildings can also impede access. Some older prisoners may also be unable to participate in activities with younger cohorts, such as exercise classes and physical work in prison workshops.[111]

47. The needs of older prisoners concerning purposeful activity can differ from those of their younger counterparts. They are more likely to have qualifications or previous work experience.[112] Many will be above retirement age when released; those given longer sentences later in life may never be released. Employability-focused education and skills programmes may be unsuited to older prisoners. As in the community, prisoners above the age of retirement are able to continue working in prison if they wish, but can choose not to.[113]

48. The social needs of older prisoners can also be distinct. Some may feel vulnerable and intimidated while among younger prisoners, and they are at greater risk of bullying and intimidation.[114] Surveys conducted by G4S at prisons they manage show that older prisoners' perception of violence is greater than that of younger prisoners at the same site. The cohort also reported higher levels of being subject to anti-social behaviour and bullying.[115] At the same time, there can be more reliance on custodial communities among the cohort as social connections with friends and family often reduce as prisoners age.[116] This can be because elderly friends and family find it more difficult to travel to visit older prisoners. Additionally, a disproportionate number of older prisoners do not have contact with their families because the nature of their offence has led them to be dissociated or, such as in some sexual offence cases, prohibited from making contact.[117]

49. Guidance about the regime for older prisoners is set out and available to prison governors in HMPPS's Model for Operational Delivery: Older Prisoners. Activity considerations are also given in RECOOP's Good Practice Guide, which was commissioned by HMPPS. The MoJ pointed to changes to the prison education system, which give governors more control over education and activity commissioning in their establishments.[118] However, evidence we received indicates that provision of appropriate activities for older prisoners varies across the prison estate. We were informed of very good practice, with some prisons

110 Independent Monitoring Boards (AGE0034)
111 Clinks and RECOOP (AGE0018)
112 Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 6; Independent Monitoring Boards (AGE0034)
113 HM Inspector of Prisons (AGE0039)
114 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036); Serco Ltd (AGE0028); Catholic Bishops' Conference (AGE0004)
115 G4S (AGE0037)
116 G4S (AGE0037)
117 Clinks and RECOOP (AGE0018)
118 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)

developing initiatives such as separate exercise classes, with gentler forms of physical activity for those with reduced mobility. Some prisons also provide activities and social forums tailored to older prisoners, which allow them to interact with other inmates of a similar age. For example, HM Inspectorate of Prisons reported that:

> Many prisons offered some specific physical education provision and some had introduced physical activities more suited to less mobile prisoners such as walking football, seated aerobics and bowls. We also saw examples of spaces for older prisoners to socialise and engage in recreation. At Standford Hill, the lounge in the chapel was reserved for older prisoners, and Moorland had created a number of 'retreats' for older prisoners on some of the house blocks.[119]

50. Prisons with a substantial population of older prisoners are reportedly more likely to have good regime provisions for the cohort.[120] Several have developed day care or activity centres for older prisoners, often in partnership with third-sector organisations. HMP Wymott, for example, provides a day centre called 'Cameo', run by the Salvation Army. This offers a range of activities for older inmates across the prison. Alan Cropper, a residential governor and lead manager for older prisoners at Wymott, described the benefits of the centre:

> The older prisoners feel safe when they go to the CAMEO centre. They are among friends and they meet prisoners from other parts of the jail whom they would not usually meet. It is well managed by the Salvation Army. There are no operational officers in there. We have had no alarm bells in the centre that I can remember, and it is well received.[121]

51. At some prisons, activities provided for older prisoners are limited or oversubscribed.[122] This can often be due to staff shortages; activities for older prisoners may depend on the availability of a single member of staff and are thus highly contingent on wider pressures in the prison.[123] Other establishments lack age-specific provisions entirely and have little purposeful activity for those prisoners not in work.[124]HMIP and the CQC cited examples of prisons where older inmates who did not work were routinely confined to their cells for 22 hours or more each day.[125] Excessive confinement and a lack of purposeful activity can negatively affect the physical and mental health of prisoners, and does not support their rehabilitation.

52. Some evidence also noted that older prisoners who are retired or unable to work can be disadvantaged financially. They may struggle to afford essentials such toiletries and phone credit.[126] The nationally recommended retirement pay for prisoners is £3.25 per week but payments vary widely across the prison estate and are higher at some establishments.[127] Non-working prisoners can also lack opportunities to reach the enhanced level of the incentives and earned privileges (IEP) scheme, since this generally depends on prisoners

119 HM Inspector of Prisons (AGE0039)
120 Prison Reform Trust (AGE0021)
121 Q113
122 Care Quality Commission (AGE0038)
123 Independent Monitoring Boards (AGE0034)
124 Independent Monitoring Boards (AGE0034); Prison Reform Trust (AGE0021); Women in Prison (AGE0027)
125 Care Quality Commission (AGE0038); HM Inspector of Prisons (AGE0039)
126 Criminal Justice Alliance (AGE0020)
127 Independent Monitoring Boards (AGE0034)

undertaking responsible paid jobs within a prison.[128] The Prison Reform Trust noted, however, that the most recent Incentives Policy Framework refers to the access of older prisoners to the scheme.[129]

Interactions with prison staff

53. Some submissions suggested that prison staff can lack awareness of the needs of older prisoners and that the cohort can lack a voice within the prison regime at some establishments.[130] As they are generally a minority group and typically more compliant and 'quieter' than their younger peers, older prisoners can be overlooked by staff focusing on the needs of the latter. Evidence from a former prisoner illustrated this 'institutional thoughtlessness':[131]

> An older prisoner requests assistance from an officer and is typically polite and waits his turn. If the officer is speaking with another prisoner, he will step back to afford them some privacy. When that conversation is finished, the older person advances to speak but is queue-jumped by a youngster. The officer smiles ruefully knowing that he risks no violence from the older prisoner. The bell goes, the old man goes to work with his question unanswered. The youngster doesn't care if he is late for work.[132]

54. A potential way to address this could be for prisons to assign specific staff to lead the management of older prisoners and represent their interests.[133] These types of arrangement already exist at some prisoners, such as HMP Wymott. Paul Grainge, Chief Officer at RECOOP, described the impetus for such initiatives:

> 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.[134]

55. **There needs to be greater recognition across the prison estate that some older prisoners will be unable to engage with the normal regime. Suitable activities and forums should be available to older prisoners to support their welfare and rehabilitation. We commend the excellent work done by some establishments, but provision of these is lacking in many prisons. *HMPPS should ensure that guidance and best practice on regime provisions for older prisoners is applied across the prison estate. We recommend that all prisons have a designated older prisoner lead, who can ensure that the older prison population has a voice and is managed most appropriately.***

128 HM Inspector of Prisons (AGE0039)
129 Prison Reform Trust (AGE0021)
130 G4S (AGE0037); De Profundis Ltd (AGE0001); Women in Prison (AGE0027)
131 G4S (AGE0037)
132 A former prisoner (AGE0006)
133 Women in Prison (AGE0027)
134 Q32

5 The health and social care of older prisoners

The healthcare needs of older prisoners

56. Older prisoners experience a heavy burden of physical and mental health conditions; among those over 60, rates of major illness have been found to be as high as 85%.[135] Diseases responsible for the greatest morbidity and mortality in the general population are particularly prevalent in older prisoners. These include ischaemic heart disease, diabetes and chronic obstructive pulmonary disorder (COPD).[136] Many older prisoners have co-morbidities,[137] and may require multiple forms of treatment and specialist services.

Covid-19 and older prisoners

57. This inquiry was launched well before the Coronavirus pandemic but, following the outbreak of the virus, we took oral evidence on the impact it could have on the older prisoner population. NHS guidance states that all people over the age of 70, and those with underlying health conditions, such as diabetes, COPD, and heart disease are at greater risk from Covid-19.[138] Studies of the virus have also indicated that morality risk is concentrated among older age groups.[139] Taken together, these factors suggest that the older prisoner cohort, many of whom have underlying health conditions and whose health is generally poorer than for other inmates and people of the same age in the community, may be particularly vulnerable to Covid-19.[140] Overcrowding on the prison estate, which predates the Covid-19 pandemic, potentially increases the risk to older prisoners; it makes social distancing more difficult. In oral evidence on 21 April, Peter Clarke, HM Chief Inspector of Prisons, said that 67% of older prisoners (defined as those aged 50 or over) were held in single-cell accommodation. Although this was a higher proportion compared to other age groups, it still meant, at the time, that just over 4,000 older prisoners were in shared accommodation.[141]

58. To reduce the spread of Coronavirus, HMPPS implemented social distancing on the prison estate. Prisons were instructed to restrict their regime, including ceasing all social visits, education, training, and employment activities (except for essential workers).[142] Social distancing of 2 metres was mandated wherever possible.[143] The intra-movement of prisoners has also been strongly discouraged. 'Compartmentalisation' and 'cohorting' approaches have been adopted in prisons, whereby groups of prisoners are housed together, to protect them from the virus or reduce the risk of their spreading it. Reverse cohorting units have been created to accommodate new prisoner receptions or transfers for 14 days

135 Ministry of Justice, Analytical Summary: The needs and characteristics of older prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (October, 2014), p 5
136 Public Health England, Health and Justice Annual Review 2017/18 (July 2018), p 14
137 Care Quality Commission (AGE0038)
138 National Health Service, "Who's at higher risk from coronavirus", accessed 24 June 2020
139 University of Oxford, "Covid-19 mortality highly influenced by age demographics", accessed 24 June 2020
140 Q11
141 Q52 [Peter Clarke]
142 Public Health England, Interim Assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England (April 2020), p 2
143 Public Health England, Interim Assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England (April 2020), p 2

to reduce the risk of the virus entering a prison.[144] Protective isolation units have been established to house known or probable Covid-19 cases and shielding units have been established to protect the most vulnerable.[145] Vulnerable prisoners have reportedly been identified in collaboration with NHS staff, though were informed of one incident where the number of vulnerable prisoners at an establishment was initially underestimated.[146] These measures have prevented the explosive outbreaks of Covid-19 on the prison estate that were initially feared if mitigation measures were not taken. As at 10 July, 520 prisoners or children across the prison estate had tested positive for the Covid-19, while 23 prisoners are believed to have died from the virus.[147] It is unclear how many of these were older prisoners.

59. Following the outbreak of Covid-19, some suggestions were made that the release of all elderly prisoners should be considered, given their potential vulnerability to the virus.[148] It was noted, however, that the offences of many older prisoners would make them ineligible for early release: around 80% of those over 70 have convictions for sexual offences.[149] The MoJ ruled out the early release of such prisoners due to potential risk to the community.[150] Professor Jennifer Shaw, of the Offender Health Research Network, highlighted the resulting dilemma, and pointed to the additional consideration of needing to provide support for older inmates who are released early:

> 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.[151]

60. In particular, it can be very difficult to find appropriate post-release accommodation for older prisoners, as Dame Anne Owers, National Chair of IMBs, pointed out:

> [E]arly 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.[152]

61. Away from the impact of the virus itself, concerns were raised about the longer-term effects of isolation on prisoners who are shielding. Isolation could greatly exacerbate the condition of those with cognitive problems or dementia.[153] Jan Fooks-Bale of the CQC pointed out the need to ensure prisoners with existing medical conditions continue to be monitored and receive treatment during efforts to contain the virus:

144 Public Health England, Interim Assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England (April 2020), p 2
145 Public Health England, Interim Assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England (April 2020), p 2
146 Q88
147 Ministry of Justice, HM Prison and Probation Service COVID-19 Official Statistics, Data to 3 July 2020 (July 2020)
148 Prisoners' Advice Service, "Coronavirus: PAS calls for the release of prisoners", accessed 4 June 2020
149 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
150 Ministry of Justice and HM Prison and Probation Service, End of Custody Temporary Release (April 2020) para 11
151 Q25
152 Q52
153 Q49 [Dame Anne Owers]

> 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.[154]

62. **We praise prison staff, HMPPS and MoJ officials for their work in responding to the Covid-19 pandemic. The virus has brought into sharp relief many of the issues affecting the prison system, including the particular health vulnerabilities of older cohorts.** ***Amid the focus on protecting prisons from Coronavirus, HMPPS must continue to ensure that prisoners with existing health conditions are monitored and receive appropriate treatment and support.***

Equivalence of care

63. An underlying principle of prison healthcare is that of equivalence of care: prisoners should be provided with, or have access to, appropriate services of treatment which are at least consistent with those available to the wider community.[155] This reflects the view that prison is a deprivation of liberty, not a sentence to poorer health. In 2019, following a recommendation by the Health and Social Care Committee's report into prison health, the National Prison Healthcare Board, which oversees coordination of prison health services, published a definition of equivalence of care for the first time:

> 'Equivalence' is the principle which informs the decisions of the National Prison Healthcare Board so that member agencies' statutory and strategic objectives and responsibilities to arrange services are met, with the aim of ensuring that people detained in prisons in England are afforded provision of and access to appropriate services or treatment (based on assessed population need and in line with current national or evidence-based guidelines) and that this is considered to be at least consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community, in order to achieve equitable health outcomes and to reduce health inequalities between people in prison and in the wider community.[156]

64. The Health and Social Care Committee's report argued that, in practice, equivalence of care is often not delivered on the prison estate.[157] The Committee identified several common problems in prison healthcare. These included:

a) Long delays in prisoners' health concerns being acted on, including worrying symptoms not being responded to in a timely way, if at all.

b) Problems getting help to prisoners in an emergency, including those experiencing suspected stroke or heart attacks.

154 Q50
155 BMA (AGE0033)
156 HM Government, National Prison Healthcare Board Principle of Equivalence of Care for Prison Healthcare in England, p 2
157 Health and Social Care Committee, Twelfth Report of Session 2017–19, Prison Health, HC 963, 1 November 2018, p16

c) Prisoners experiencing delays in accessing required medicines, including prescription medication.

d) Difficulties in prisoners seeing a dentist, GP, speech and language therapist or an optician.

e) Poor complaints handling processes, with prisoners' complaints or those made on their behalf about healthcare often going unanswered.[158]

65. In evidence for our inquiry, it was pointed out that problems with prison healthcare in general will have a disproportionate impact on the older prison population due to the higher prevalence of health conditions among the cohort.[159]

Health screening

66. Prisons are supposed to provide an initial health and social care screening to new inmates on reception, followed by a second screening within a few days.[160] According to the CQC, overall compliance with the requirement for an initial screening has improved, though the provision of timely secondary screening and further monitoring thereafter is more variable in reception and remand prisons that have a high churn of prisoners.[161] A lack of secondary screening is problematic, as it often provides a better opportunity to identify health conditions and care needs.[162] Access to screening for age-related health conditions has also reportedly improved overall, with services brought in-house in some prisons, improving access.[163] But provision of such screening across the estate remains inconsistent, with some older prisoners facing significant delays for assessments for conditions such as dementia.[164]

Staff

67. Some evidence suggested that while prison and healthcare staff are caring towards older prisoners, they do not always have a good understanding of how to assess and manage the specific needs of the cohort.[165] The CQC reported that having a designated lead for older prisoners, who can coordinate their assessment, care, and onward referral generally produces better health outcomes. But prison healthcare teams do not always have such a lead and often lack other means to advocate for the needs of older prisoners.[166] Clinks and RECOOP noted that as prison healthcare is designed to be reactive, older prisoners are expected to take the lead in applying to see health service providers. However, older prisoners may be reluctant to display vulnerability about age-related health issues.[167] In addition, information about accessing health and care services is not always easily

158 Health and Social Care Committee, Twelfth Report of Session 2017–19, Prison Health, HC 963, 1 November 2018, pp25–26.
159 Independent Monitoring Boards (AGE0034)
160 Health and Social Care Committee, Twelfth Report of Session 2017–19, Prison Health, HC 963, 1 November 2018, para 42
161 Care Quality Commission (AGE0038)
162 Care Quality Commission (AGE0038)
163 Care Quality Commission (AGE0038)
164 Care Quality Commission (AGE0038); HM Inspector of Prisons (AGE0039)
165 British Association for Counselling and Psychotherapy (AGE0011)
166 Care Quality Commission (AGE0038)
167 Clinks and RECOOP (AGE0018)

available, making self-referral difficult.[168] More generally, prisons often face recruitment and retention issues among healthcare staff, which particularly affects the treatment of prisoners with long-term health conditions.[169]

Attendance at medical appointments

68. Issues around older prisoners attending external medical appointments were frequently cited in evidence. As the Health and Social Care Committee's 2018 inquiry into prison healthcare highlighted, poor attendance at medical appointments is a problem affecting the whole prison population.[170] But older prisoners are disproportionately affected as, due to the higher prevalence of health conditions in the cohort, they are more likely to need treatment at NHS hospitals or other external healthcare facilities.[171] According to the Nuffield Trust, 35% (8,867) of outpatient appointments for prisoners aged over 50 were missed in 2017/18.[172] Cancellations among older prisoners were more than double those of the general population aged over 50, raising serious questions about whether equivalence of care is being delivered.[173]

69. Prison regulations require two officers to escort prisoners to appointments outside the prison. This is despite the lower risk of older prisoners absconding.[174] Each prison is allocated a certain number of health escorts per day, but it is not clear how this amount relates to the size or category of the prison or the medical needs of its inmates.[175] Staff shortages or other demands within a prison can further limit escort availability.[176] Given the fixed number of escorts, decisions often have to be made as to which prisoner's healthcare needs should be prioritised through attendance of an external appointment.[177] Both the Nuffield Trust and Royal College of General Practitioners raised concerns about how these decisions are made and pointed to the risks faced by prisoners whose health needs are deemed less urgent.[178] The BMA suggested that, typically, routine appointments for long-term or chronic conditions are given a lower priority than those for acute cases, such as when a prisoner has a suspected broken bone.[179] Older prisoners are disproportionately impacted by this prioritisation, and the cancellation of routine appointments can lead to increased deterioration of health and delays to the diagnosis and treatment of conditions.[180]

70. In their response to the Health and Social Care Committee's concerns about missed medical appointments, the Government focused on their plans to recruit more prison officers and therefore increase the availability of staff to escort prisoners to appointments.[181] While increased escort availability would help to reduce the number of missed appointments, several submissions called for more innovative solutions. These include

168 Care Quality Commission (AGE0038)
169 BMA (AGE0033)
170 Health and Social Care Committee, Twelfth Report of Session 2017–19, Prison Health, HC 963, 1 November 2018, para 29, para 71–76
171 Clinks and RECOOP (AGE0018)
172 Nuffield Trust (AGE0026)
173 Nuffield Trust (AGE0026)
174 Clinks and RECOOP (AGE0018)
175 Nuffield Trust (AGE0026)
176 BMA (AGE0033)
177 Nuffield Trust (AGE0026)
178 Nuffield Trust (AGE0026); Royal College of General Practitioners (AGE0015)
179 BMA (AGE0033)
180 Royal College of General Practitioners (AGE0015)
181 HM Government, Government Response to the Health and Social Care Committee's Inquiry into Prison Health, CP 4, January 2019, para 7.2–7.5

making greater use of telephone medical appointments and tele-medicine, as suggested by Serco, the Nuffield Trust and Royal College of General Practitioners. Such initiatives would not only improve prisoners' access to medical advice but would also reduce the demand for prison escorts.[182]

71. **An ageing prison population will increase pressure on prison healthcare. To ensure an equivalent standard of care as in the community, it is important that prison healthcare services are appropriately resourced, and staff have awareness of age-related health conditions.** ***We recommend that all prison healthcare teams have a designated older prisoner lead, and that training on age-related health-issues is available to all prison staff. The Government must also ensure that prison healthcare services are resourced in line with the needs of an older population.***

72. **Older prisoners are disproportionately affected by cancellations to external medical appointments, and their health can be seriously impacted by non-attendance.** ***While increasing the number and availability of prison staff to escort prisoners to appointments is important, we also recommend that the Government review increasing the use of telemedicine and other innovative ways to give prisoners access to medical advice.***

Mental healthcare provision

73. There is a high prevalence of mental health disorders among older prisoners. More than half have a mental health disorder and 30% a diagnosis of depression.[183] Prisoners aged 50 to 59 have the highest risk of suicide at a rate of 13.4 self-inflicted deaths per 1,000 prisoners.[184] In addition, particular concerns were raised in evidence about dementia. Its prevalence in prisons is largely unknown: Age UK reported that the diagnosis rate in the over-55 prison population was only 5%, compared to 68.7% in the general over-65 population, highlighting how the condition is overlooked in prisons.[185] Limited research has been conducted on the issue, though a 2019 study indicated that up to 7% of the older prison population experience symptoms of dementia or mild cognitive impairment.[186] Recognising the symptoms of dementia in prisoners is made more difficult in part because the repetitive nature of the prison routine and informal peer support can mask the signs of deterioration.[187] Older prisoners can also be reluctant to disclose any symptoms due to stigma around the condition.[188] But several submissions noted a lack of awareness among prison staff in how to identify and manage dementia.[189] As a result, behavioural

182 Nuffield Trust (AGE0026); Care Quality Commission (AGE0038)
183 Criminal Justice Alliance (AGE0020)
184 British Association for Counselling and Psychotherapy (AGE0011)
185 Age UK (AGE0025)
Dementia diagnosis rates are calculated by dividing the number of people diagnoses with dementia (as reported in national health statistics) by the total estimated number of people living with dementia. See: https://www.dementiastatistics.org/statistics/diagnoses-in-the-uk/
186 Offender Health Research Network, University of Manchester (AGE0030)
187 Care Quality Commission (AGE0038)
188 British Association for Counselling and Psychotherapy (AGE0011)
189 Care Quality Commission (AGE0038); British Association for Counselling and Psychotherapy (AGE0011); Offender Health Research Network, University of Manchester (AGE0030)

symptoms, such as forgetfulness, can be misinterpreted as the inevitable signs of ageing or as noncompliance.[190] We were informed of cases where prisoners lost privileges earned under the Incentives and Earned Privileges Scheme because of the latter.[191]

74. According to the CQC, prisoners can face long delays accessing memory assessment services.[192] Use of these can be challenging to facilitate as they rely on a prisoner attending a centre over a prolonged period, while application of the outcome can be difficult as the assessment environment may be very different to the prison setting.[193] In addition, prison dementia services do not always reflect best practice or show consistency; for example, age thresholds for screening vary among different prisons.[194] The MoJ's submission cited good practice, reporting how some prisons have increased services for prisoners with dementia and provided training for staff:

> HMP Stafford is also providing a dementia service, which includes screening all those over 50, a diagnostic clinic within the prison, behaviour management advice and training for officers. This service commenced in August 2019 and will be extended to HMP Oakwood later this year.[195]

75. However, the Prison Reform Trust highlighted that care for individuals with dementia is particularly difficult to manage in a prison setting, citing a consensus view from Independent Monitoring Boards "that dementia patients cannot be well cared for in a prison environment".[196] Some evidence questioned whether prisoners with severe dementia should remain on the prison estate. The Howard League suggested that if prisoners can no longer remember or understand why they are imprisoned, it is unlikely that they will be rehabilitated or deterred by their sentences. As such, the Howard League claims, continuing to incarcerate them does not fulfil penal aims.[197] The BMA suggested that secure hospitals or similar institutions may be more appropriate for the management and care of prisoners with severe dementia.[198] Accounts we received of the experience of such prisoners strengthened these arguments:

> Mr X has severe dementia and every day he believes he has a taxi arriving to take him home to his wife. Consequently, he refuses to return to his cell until the staff tell him to get his coat because his taxi has arrived. He then enters the cell to get his coat upon which the door is slammed. He then spends many hours, including during the night, banging the door trying to get out to reach his taxi.[199]

76. **The prevalence of dementia in prisons is poorly understood and prison staff can lack awareness of the condition.** ***All older prisoners should have access to screening services for dementia, and prison officers who work with older prisoners should receive training on recognising and managing its symptoms.***

190 British Association for Counselling and Psychotherapy (AGE0011)
191 Clinks and RECOOP (AGE0018)
192 Care Quality Commission (AGE0038)
193 Care Quality Commission (AGE0038)
194 Care Quality Commission (AGE0038)
195 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
196 Prison Reform Trust (AGE0021)
197 The Howard League for Penal Reform (AGE0013)
198 Ibid; BMA (AGE0033)
199 Dr Dennis Eady (AGE0008)

77. **Continuing to incarcerate prisoners with severe dementia, who may no longer remember or understand why they are imprisoned, raises practical and ethical considerations, especially as their condition is very difficult to manage on the prison estate. Equally, the Committee recognises that a significant element of this cohort are convicted for historic sexual offences. Particular attention must be given to the feelings of victims of such cases, both because of the nature of the offending itself and because of delays often experienced in bringing such perpetrators to justice. We recognise that some of those victims may consider that alternative custody arrangements and potential early release of some individuals risks adding to the suffering that they have already endured. This must be taken into consideration. *The Government should review whether alternative arrangements for housing prisoners with advanced dementia would be more appropriate in some circumstances.***

Social care for older prisoners

78. Though a need for support can arise at any age, older prisoners are more likely to be among those eligible for social care.[200] Care needs can arise as a result of mobility or sensory problems, disability, and health conditions,[201] which have a higher prevalence among the older prisoner population than other prison age groups. Under the Care Act 2014 and the equivalent Welsh legislation, the Social Services and Well-being (Wales) Act 2014, local authorities in whose area a prison is located are responsible for providing its social care.[202] The threshold for eligibility for care and support service for prisoners are the same as in the wider community.[203] Prisons, healthcare services and individual prisoners with needs can all request a social care referral assessment.[204] Evidence indicated that the Acts have supported some improvements in the provision of social care in prisons by clarifying responsibilities for delivery of care and encouraging good practice towards the identification and referral of prisoners' care needs.[205]

79. However, standards of social care are highly inconsistent among different prisons. HMIP and the CQC's joint thematic report, *Social Care in Prisons in England and Wales*, published in 2018, described the quality of prison social care services being subject to a 'postcode lottery' across the prison estate, with the care needs of prisoners going unmet in a number of establishments.[206]

80. Not all prisons have effective procedures in place to identify prisoners with social care needs and to assess those needs.[207] At some establishments, the identification of care requirements is the responsibility of healthcare staff as part of the secondary screening following a prisoner's reception into the prison. However, as noted in the previous section,

200 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England an (AGE0036)
201 Offender Health Research Network, University of Manchester (AGE0030)
202 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036); Older People's Commissioner for Wales (AGE0007)
203 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
204 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
205 Association of Directors of Adult Social Services (ADASS) (AGE0024); Older People's Commissioner for Wales (AGE0007); Prison Reform Trust (AGE0021)
206 HM Inspectorate of Prisons and the Care Quality Commission, Social Care in Prisons in England and Wales: A thematic report, (October 2018), page 9–10
207 Care Quality Commission (AGE0038)

not all prisoners receive that secondary screening.[208] In the joint thematic report, some prison authorities were also found to have poor awareness of social care. Consequently, self-referrals from prisoners were not assessed appropriately and were not passed on to local authorities for further assessment.[209] In addition, the time taken by local authorities to carry out assessments varies widely, as HMIP described:

> In our thematic report, we noted that we were pleased to see that the longest delay at Littlehey was 10 days. However, we also found delays of up to five months [at other prisons].[210]

81. The quality of social care provided varies across the prison estate, with good practice occurring where there are more older inmates in a prison.[211] HMIP noted prisons with appropriate care planning and services that met individual need.[212] At other prisons, however, care plans for individual prisoners are not always adequate or kept up-to-date and the delivery of social care packages is variable.[213] There can be difficulties with external social care workers regularly visiting prisons to provide care.[214] Gaps have also been noted in care provision for prisoners needing assistance with personal care but who do not meet the eligibility criteria for social care.[215]

82. Delivery of effective social care for prisoners also relies on appropriate accommodation and adjustments to the physical environment being provided to those with support needs. However, as set out in Chapter 3, the standard accommodation in many prison establishments is not suited to prisoners with reduced mobility, disabilities, or health problems that can result in care needs and appropriate reasonable adjustments are not always provided. In written evidence, the CQC also noted that prison inpatient units are increasingly being used to accommodate older prisoners requiring social care. This is because the location and availability of healthcare staff are considered to make such units most appropriate for providing care. However, this can lead to increased demands on inpatient staff time, potentially detracting from the clinical care of prisoners with acute medical need. It also means prisoners receiving social care are separated from the wider prison regime.[216]

Collaboration between prisons and local authorities

83. As noted above, under the Care Act 2014, local authorities are responsible for providing social care in prisons and are required to work with prison authorities and healthcare providers to coordinate the delivery of services.[217] Each prison is expected to have a local delivery board, chaired by the governor and including local authorities and

208 HM Inspector of Prisons (AGE0039)
209 HM Inspector of Prisons (AGE0039)
210 HM Inspector of Prisons (AGE0039)
211 Q62
212 HM Inspector of Prisons (AGE0039)
213 HM Inspector of Prisons (AGE0039); Care Quality Commission (AGE0038)
214 HM Inspector of Prisons (AGE0039); Independent Monitoring Boards (AGE0034)
215 HM Inspectorate of Prisons and the Care Quality Commission, Social Care in Prisons in England and Wales: A thematic report, (October 2018), p 7
216 Care Quality Commission (AGE0038)
217 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)

healthcare and social care providers.[218] In practice, the effectiveness of joint working varies. According to ADASS, there is a common issue of responsibility for the care of individual prisoners being passed from organisation to another, rather than each recognising their shared responsibility:

> Healthcare providers will complain of having to provide services to individuals who they consider require care and support from the local authority, who in turn, may assess the individual as not having eligible care and support needs or possibly may struggle to find a provider who can reliably meet the needs even if they are eligible to be supported.[219]

84. In HMIP and the CQC's joint thematic report, good collaboration between prisons and local authorities in providing social care was found to occur mostly when a memorandum of understanding (MoU) had been established between the prison, local authority, and social care provider.[220] These helped to clarify the responsibilities of each regarding social care.[221] But several prisons did not have MoUs in place, while others were found to be out-of-date or lacking in detail.[222] Prisons are required to sign MoUs with local authorities under HMPPS policy. In written evidence, the Government stated that as of July 2019, approximately 90% of prisons had MoUs either signed or in draft awaiting signature. They noted, however, that neither HMPPS nor the Department for Health and Social Care can mandate local authorities to sign these agreements with prisons.[223]

85. More broadly, evidence pointed to a lack of strategic planning for provision and coordination of social care services in prisons. Peter Clarke, HM Chief Inspector of Prisons, noted a disjoint between MoJ plans to reconfigure the prison estate and the role of local authorities as prison social care providers:

> 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.[224]

86. The joint thematic report highlighted that, due to this lack of strategic planning, prison social care is focused on current needs without adequate consideration of what will be required in the near future as a result of the prison population ageing.[225] Its main recommendation was that the Justice Secretary lead cross-governmental work to develop

218 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
219 Association of Directors of Adult Social Services (ADASS) (AGE0024)
220 Age UK (AGE0025)
221 HM Inspectorate of Prisons and the Care Quality Commission, Social Care in Prisons in England and Wales: A thematic report, (October 2018), p 25
222 HM Inspectorate of Prisons and the Care Quality Commission, Social Care in Prisons in England and Wales: A thematic report, (October 2018), p 26
223 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
224 Q56
225 HM Inspectorate of Prisons and the Care Quality Commission, Social Care in Prisons in England and Wales: A thematic report, (October 2018), p 7

a strategy for prison social care and promote better coordination and consistency in its delivery. In its response to that report, HMPPS rejected this recommendation on the basis that delivery of social care in prisons is the responsibility of local authorities and beyond its or the MoJ's remit.[226] In their submission to us, the Government reported that 'a number of actions have already been completed' in response to the joint thematic report, with an update on progress to be provided 'in due course'.[227]

87. **An ageing prison population will increase demand for social care services in prisons. While the Care Act 2014 has brought some improvements, standards of provision are highly variable across the estate. A more strategic and coordinated approach is needed to improve consistency and ensure effective collaboration between prisons, local authorities and other organisation involved in delivering care. *In its response to this report, the Government should update the Committee on the progress of the action plan for social care in prisons in England and Wales, published following HMIP and the CQC's joint thematic report. The Government should also set out its plans for the future provision of social care in prisons.***

Care from other prisoners

88. Older prisoners with social care needs can rely on the support of other, often younger, inmates. At several prisons these arrangements have been formalised into 'buddy' schemes and similar programmes, where trained prisoner carers provide for more routine support needs. RECOOP and Devon County Council have developed such an initiative for three prisons in the county:

> This is a formalised programme where Buddies are required to undertake a two-week training package. Buddies provide non intimate support, promoting independence and empowering recipients to take control of their own well-being and health. RECOOP provides ongoing mentoring and management support to oversee the Buddies' work.[228]

89. In evidence, schemes like this were generally viewed as an effective way to support older prisoners with independent living, and to build empathy between different generations of prisoners.[229] However, concerns were raised that buddy systems have been set up in some prisons without adequate training and oversight for those prisoners giving care.[230] This can affect the quality of the care delivered and enable buddies to exploit older prisoners they are assisting.[231]

90. **Peer support or 'buddy' schemes can be an effective way to help meet the care needs of older prisoners. We commend the good work done by some prisons in partnership with third sector organisations to develop such initiatives. *Prisons must ensure that prisoners providing care to other inmates are suitably trained and have appropriate oversight.***

226 HM Prison and Probation Service, Action Plan: HMP Thematic – Social Care in Prisons in England and Wales (December 2018)
227 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
228 Clinks and RECOOP (AGE0018)
229 Independent Monitoring Boards (AGE0034); Serco Ltd (AGE0028)
230 Criminal Justice Alliance (AGE0020); Offender Health Research Network, University of Manchester (AGE0030); Q58
231 Offender Health Research Network, University of Manchester (AGE0030)

Palliative and end of life care

91. The average life expectancy of a prisoner is 56.[232] In the UK as a whole, average life expectancy is around 81.[233] Prisoners suffering from incurable or terminal health conditions can apply for early release. However, not all will be eligible and some prisoners, particularly those who have served long sentences or do not have social connections in the community, may wish to remain in prison.[234] The increase in the older prison population has therefore led to a rise in the need for palliative and end-of-life care on the prison estate.

92. Evidence suggested that the standard of end-of-life care is inconsistent across the estate, though improving overall. In 2018, HMPPS launched the Dying Well in Custody Charter, which sets out standards and guidelines for palliative and end-of-life care in prisons.[235] IMBs noted that this has been usefully applied by some prisons.[236] Some establishments have developed specific end-of-life care facilities, often located within inpatient units.[237] A prison's relationship with local hospices can play an important role in the quality of end-of-life care, and we received examples of effective collaboration:[238]

> At HMP Dartmoor (2018), health staff won a national nursing award for the provision of end of life care, in collaboration with a local hospice. This was in recognition of staff supporting patients to die with dignity within the prison, achieved with support from trained prisoner "buddies", cell visits and regular palliative care clinics.[239]

93. However, care planning for terminally ill prisoners has not been consistently adequate at all prisons.[240] There is no overall strategy for how prisons should manage inmates at the end of their lives, including as to which establishments should have palliative care facilities.[241] Dame Anne Owers noted that one prison had established a palliative care unit which had never been used for providing palliative care.[242]

Release on compassionate grounds

94. It is possible for prisoners near the end of their lives, or those with conditions that are difficult to treat in prison, to apply for release before their sentence is complete.[243] Release can either be on a temporary licence (ROTL) or early release on compassionate grounds.[244] The risk a prisoner poses to the public has to be assessed as minimal for the application for early release to be granted; assessment are also made of the medical condition of the prisoner; their remaining life expectancy; the impact continuing incarceration will have on this; and the benefit early release will bring to a prisoner and their family.[245]

232 BMA (AGE0033)
233 Office for National Statistics, 'National life tables, UK: 2016 to 2018', accessed 14 July 2020
234 Q67 [Peter Clarke]
235 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
236 Independent Monitoring Boards (AGE0034)
237 HM Inspector of Prisons (AGE0039)
238 Q67 [Dame Anne Owers]
239 HM Inspector of Prisons (AGE0039); Care Quality Commission (AGE0038)
240 HM Inspector of Prisons (AGE0039); Prisons and Probation Ombudsman (AGE0042)
241 Independent Monitoring Boards (AGE0034)
242 Q67 (Dame Anne Owers)
243 Prisons and Probation Ombudsman, Learning from PPO investigations: Older Prisoners (June 2017), p 23
244 Prisons and Probation Ombudsman, Learning from PPO investigations: Older Prisoners (June 2017), p 23
245 Prisons and Probation Ombudsman, Learning from PPO investigations: Older Prisoners (June 2017), p 23

95. Evidence received for this inquiry indicated that early release application processes could be improved. Submissions from the Prisons and Probation Ombudsman (PPO), IMB and the Howard League pointed to the length of time applications can take to manage; the latter highlighted cases where terminally ill prisoners had died while waiting for theirs to be processed.[246] The PPO also stated that compassionate release processes in some prisons are disorganised and poorly managed, with no single individual having overall responsibility for the progress on an application. They recommended that prisons designate a member of staff to be responsible for coordinating the progress of an application for compassionate release.[247]

96. **The ageing prison population has and will continue to increase the need for end-of-life and palliative care in prisons. We welcome the publication of the Dying Well in Custody Charter and the good practice at some establishments. But standards are not consistent across the estate. In addition, as mentioned previously, we recognise that there has been delay in providing justice for the victims of some prisoners. Again, attention must be given to the needs of the victims of those crimes. *The MoJ must ensure that provision of end-of-life and palliative care is properly resourced and coordinated to reflect the current and future needs of the prison population. The MoJ should also review whether, in certain circumstances, terminally ill prisoners nearing the end of their lives would be better cared for outside of the prison estate and how effectively current arrangements for compassionate release are operating in practice.***

97. **Prisoners applying for early release on compassionate grounds should have their applications processed in an efficient and timely manner. This is especially important for terminally ill prisoners near the end of their lives. *We recommend prisons identify a single member of staff to have overall responsibility for progressing an application for compassionate release.***

246 Independent Monitoring Boards (AGE0034); The Howard League for Penal Reform (AGE0013); Prisons and Probation Ombudsman

247 Prisons and Probation Ombudsman (AGE0042)

6 Release and resettlement of older prisoners

98. Older prisoners can face distinct challenges on their release from prison. Those who have served a long sentence and experienced institutionalisation can, in particular, struggle to reintegrate into society.[248] They may be unfamiliar with using new technologies; applying for employment and housing; and accessing benefits and pensions.[249] Relationships older prisoners had prior to entering custody may have broken down due to the length of their sentence or the nature of their offence. Often, other prisoners can, in effect, become their surrogate family.[250] Release can therefore create social isolation and older prisoners may lack social support in the community. Those receiving medical treatment or social care in prison will need to be able to continue to access it after their release and find appropriate accommodation.[251]

Preparing for release

99. For the reasons set out above, older prisoners may require additional support and guidance prior to their release to prepare them to re-join society. This could include practical information around using modern technology, applying for housing and benefits, and accessing community health and social care.[252] We were informed of good practice by prisons in partnership with voluntary sector organisations. For example, at HMP Eastwood Park, a day centre set up by RECOOP has been running since 2011, providing older women prisoners with pre-release support and guidance.[253] In addition, the Prison Reform Trust reported how:

> Two prisons were working with the Ormiston Trust, to help maintain relationships with families whilst in custody. Restore Support Network offer older prisoners through the gate support and a peer network that encourages positive relationships. RECOOP staff in HMP Leyhill help prepare older people for release by accompanying them on day trips into the community to help them acclimatise and with practical support such as applications for bus passes.[254]

100. However, evidence indicated that resettlement preparation and planning in many prisons tends to be orientated towards younger prisoners and does not consider the specific needs that older prisoners can have.[255]

101. In addition, older prisoners can struggle to transfer to open prisons to access release on temporary licence (ROTL). This can be an effective way to support their resettlement and allow them gradually to re-integrate into society.[256] However, only two open prisons

248 Women in Prison (AGE0027)
249 Age UK (AGE0025)
250 G4S (AGE0037)
251 Serco Ltd (AGE0028)
252 Age UK (AGE0025); British Association for Counselling and Psychotherapy (AGE0011)
253 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
254 Prison Reform Trust (AGE0021)
255 G4S (AGE0037); Independent Monitoring Boards (AGE0034); HM Inspector of Prisons (AGE0039)
256 Clinks and RECOOP (AGE0018)

currently accept prisoners convicted of sexual offences (Leyhill and North Sea Camp).[257] As already noted, almost half of older prisoners are serving sentences for sexual offences. Consequently, a substantial backlog of prisoners suitable for open conditions await transfer to these prisons, for a year in some cases according to the IMB.[258]

102. **Older prisoners can experience greater levels of institutionalisation and be less able to live independently following their release compared to younger cohorts. Many will require additional support to prepare them to re-join society. *Release programmes and guidance that are age relevant, focusing on issues such as using technology, finding accommodation, and accessing pensions and benefits, should be available to all older prisoners.***

Release accommodation

103. Finding appropriate accommodation for prisoners after their release is central to ensuring their successful resettlement and preventing reoffending.[259] However, it can be very difficult for older prisoners and prison authorities assisting them to find post-release accommodation. A large proportion of the cohort moves to approved premises after release. This may be required as part of an older prisoner's licence conditions, in reflection of the nature of their offence.[260] Residence in approved premises may also be necessitated as many local authorities and housing agencies will not accept people who have been convicted of sexual offences, which many older prisoners have committed.[261] However, approved premises are often not able to accommodate individuals with disabilities, accessibility needs or complex health conditions.[262] In oral evidence, Paul Grainge, Chief Officer of RECOOP, highlighted this and some of the wider issues older released prisoners can face in 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.[263]

104. Residence in approved premises is temporary. It was noted that, for the same reasons as above, it can be particularly difficult for older prisoner to find housing following the initial licence period after their release.[264] The lack of social connections in the community some older prisoners face can exacerbate this issue further, as they may not have family or friends with whom they can stay.[265] These problems can also affect prisons not required to live in approved premises.[266]

257 Independent Monitoring Boards (AGE0034)
258 Independent Monitoring Boards (AGE0034)
259 Association of Directors of Adult Social Services (ADASS) (AGE0024);
260 Clinks and RECOOP (AGE0018)
261 Criminal Justice Alliance (AGE0020)
262 Criminal Justice Alliance (AGE0020); Clinks and RECOOP (AGE0018)
263 Q35
264 Q35; G4S (AGE0037)
265 G4S (AGE0037)
266 Q164

105. Difficulties finding post-release accommodation for older prisoners can result in their remaining in prison despite being eligible for parole.[267] As well as being detrimental to older prisoners' resettlement, this can also contribute to 'bed blocking' and overcrowding within a prison.[268] When accommodation cannot be found before the end of an older prisoner's sentence, this can result in their being released to no fixed abode and facing homelessness.[269] Evidence we received from a former prisoner highlighted incidences of this:

> [A] person I knew was told he would have a flat upon release and when he arrived at his probation office was told he would have to find his own accommodation as there was nowhere available for him, this after 6 months of writing to everyone he knew to make this arrangement. One disabled gentleman confined to a wheel chair had no idea where he would be placed even on the day of his release when a taxi turned up to transport him to his probation office. Another person I met at my Hostel had to go to the extent of pitching a tent in the woods at the age of 70 before the local authority would consider his case and he had a physical infirmity as well.[270]

106. **There is a shortage of suitable accommodation for older prisoners following their release, which can undermine their rehabilitation and prevent them from successfully re-integrating into society. We are particularly concerned about reports of older individuals being released to no-fixed abode. *With the older prison population likely to rise further, and the number of prison places set to increase, the Government must ensure that there is suitable provision of age-appropriate post-release accommodation, including housing for those with complex health or care needs.***

Continuity of health and social care

107. Older prisoners in receipt of medical treatment or social care in prison will need to continue to receive it after their release, to ensure both their health and rehabilitation. The level of care and support a prisoner receives in custody may be different to what is required in the community. Though prison can be difficult for older prisoners in many respects, basic needs, such as food and clean clothes, are readily available and some older prisoners may not be able to fulfil these independently following their release.[271] For this reason, some individuals not receiving support in prison may need it in the community.[272]

108. Evidence indicated that there has been some improvement in the planning, preparation and provision of social care for prisoners leaving custody since the implementation of the Care Act 2014.[273] However, we heard that cooperation and integration between the often multiple organisations involved in arranging an older prisoner's post-release care is not always adequate. Some older prisoners are released without their care assessment or plan being referred on to providers in the community. This can be because prison care providers are not made aware that they are about to be released.[274] The CQC reported that where

267 Independent Monitoring Boards (AGE0034); Criminal Justice Alliance (AGE0020); Prison Reform Trust (AGE0021)
268 Clinks and RECOOP (AGE0018)
269 Association of Directors of Adult Social Services (ADASS) (AGE0024); Age UK (AGE0025)
270 A former prisoner (AGE0005)
271 Serco Ltd (AGE0028)
272 Association of Directors of Adult Social Services (ADASS) (AGE0024)
273 Association of Directors of Adult Social Services (ADASS) (AGE0024)
274 Q37

care plans for older prisoners are in place, their quality relies on being able to confirm an individual's destination.[275] HMIP noted cases of poor communication between prisons and local authorities regarding the release of prisoners in receipt of social care, including delays in providing discharge notifications to local authorities.[276] We were also informed of disputes between different local authorities over which was responsible for providing care to an individual after their release. According to ADASS, it is not always clear whether the local authority providing care to someone in prison continues to have responsibility for their support following release.[277]

109. Concerns were also raised about prisoners being released without prescribed medicines. This disproportionately affects older prisoners as many are prescribed multiple forms of medication, meaning there is a higher risk of interrupting their treatment, with serious consequences for their health.[278] In addition, older prisoners are frequently released without being registered with a GP and any formal ID, which can prevent them from registering with one after they are released.[279]

110. In written and oral evidence, the Government highlighted the development of the NHS's new RECONNECT service, which will support vulnerable individuals with complex health and care needs engage with health services as they leave prison.[280] According to the Government, these services will engage with prisoners before release, and support resettlement.[281] NHSE/I has committed £20 million to the RECONNECT over the next five years, and the development of the service was welcomed by some evidence we received.[282]

111. **Prisons, local authorities, and health and care providers do not always work together effectively to ensure continuity of older prisoners' health and social care. This can have a detrimental impact on an individual's health and their efforts to re-integrate into society.** ***The development of the new RECONNECT service is welcome, but we recommend that the Government implement further measures to promote integration between organisations involved in continuity of prisoners' health and social care.***

112. **We are concerned about reports of older prisoners being released without prescription medication or without being registered with a GP.** ***We recommend all older prisoners are supported to register with a GP prior to release; where a prisoner is unable to do so, they should be provided with guidance and formal ID so they are able to register once they are released into the community. We further recommend that HMPPS implement safeguards to ensure all prisoners are provided with any prescription medication on their release.***

275 Care Quality Commission (AGE0038)
276 HM Inspector of Prisons (AGE0039)
277 Association of Directors of Adult Social Services (ADASS) (AGE0024)
278 Care Quality Commission (AGE0038)
279 Prison Reform Trust (AGE0021); Women in Prison (AGE0027); Q37
280 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
281 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
282 Serco Ltd (AGE0028); Association of Directors of Adult Social Services (ADASS) (AGE0024)

7 A national strategy for older prisoners

113. The 2013 Justice Committee inquiry into older prisoners called on the Government to produce a national strategy for the cohort. The Committee considered that the ageing prison population and the severity of the needs of some older prisoners warranted a specific approach, to provide for minimum standards and effective and equitable care.[283] The Government rejected the recommendation, stating that it was inappropriate to generalise about older prisoners and that their needs should be managed on an individual basis, not according to their age.[284] Though they accepted that older prisoners are likely to have greater health and social care needs, the Government argued that those were best catered for within overall policy for prisoners with care requirements.[285]

114. In its submission to this inquiry, the Government reaffirmed its response to our predecessor's call for a national strategy:

> MOJ and HMPPS are not yet persuaded that categorisation of prisoners by age is necessarily helpful given the wide range of needs, abilities and requirements that will be included in the older prisoner cohort.
>
> As set out in our response to the Justice Select Committee report of 2013, our view remains that prisoners should be managed based on individual needs not solely based on their age.[286]

115. In the years since our predecessor's inquiry, there have been indications that the Government was considering producing a national strategy. Peter Clarke, HM Chief Inspector of Prisons, told us that he attended an MOJ-led steering group working on a national strategy for older prisoners in late 2017, but that it had only met once and he had heard nothing since.[287] In written evidence to the previous Justice Committee's inquiry, *Prison Population 2022*, the Prisons and Probation Ombudsman also mentioned that he had been a member of this steering group.[288] The output of this work appears to have been HMPPS's Model for Operational Delivery (MOD) for older prisoners, published in April 2018.

116. By the MoJ's admission, the MOD is not a strategy, but is designed to inform prison governors and directors and give a framework for managing older prisoners, setting out the services and activities they need, good practice examples, and other considerations for effectively supporting the cohort.[289] At nearly 50 pages, the MOD includes guidance on:

(1) the regime and activity considerations for older prisoners;

(2) Supporting older prisoners' needs, including around health and social care, and release and resettlement;

283 Justice Committee, Fifth Report of Session 2013–14, Older Prisoners, HC 89, 12 September 2013, para 136
284 Ministry of Justice, Government response to the Justice Committee's Fifth Report of Session 2013–14: Older Prisoners, Cm 8739, November 2013, page 17
285 Ministry of Justice, Government response to the Justice Committee's Fifth Report of Session 2013–14: Older Prisoners, Cm 8739, November 2013, page 17
286 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
287 Q81
288 Prisons and Probation Ombudsman (PPP0031)
289 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)

(3) Providing palliative and end of life care and other arrangements for prisoners nearing the end of their lives.[290]

117. As the MOD states, it was developed "in recognition of the sizeable and growing proportion of older prisoners in the prison estate and the need to think differently about how we manage them to ensure we can better meet their needs."[291] The MOD: Older Prisoners is one of several models for operational delivery designed support the reconfiguration of the prison estate into reception, training and resettlement prisons, as part of the Prison Estate Transformation Programme (PETP).[292]

118. Though the development of the MOD was welcomed in evidence we received, it was pointed out that it falls short of a strategy.[293] The MOD's provisions are optional, with prison governors under no obligation to implement the guidance it contains. The Prison Reform Trust and the joint submission from Clinks and RECOOP and questioned the extent to which governors across the prison estate had implemented the model since its publication.[294] The MOD is also focused on operations within prisons; as Peter Clarke highlighted, a strategy would set out overarching objectives and resourcing towards meeting the current and projected demands created by an ageing prison population:

> 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.[295]

119. Dame Anne Owers, National Chair of IMBs, echoed this:

> 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.[296]

120. In oral evidence, Prisons Minister Lucy Frazer indicated that the MoJ's position on a national strategy for older prisoner had shifted:

290 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
291 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
292 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England and Improvement (AGE0036)
293 Clinks and RECOOP (AGE0018); Age UK (AGE0025); Prison Reform Trust (AGE0021)
294 Clinks and RECOOP (AGE0018); Prison Reform Trust (AGE0021)
295 Q83
296 Q85 [Dame Anne Owers]

> [It] is something we need to seriously think about. I am in favour of having an overarching strategy, particularly on things like accommodation. We have an opportunity now to build 10,000 additional places, which is going to include a number of new prisons. This is a good opportunity to think about how we configure that accommodation, particularly having in mind the fact that we have an older cohort.[297]

121. **We disagree with the argument that older prisoners' needs are too wide-ranging to generalise. Though it is important to treat each prisoner as an individual, there is a commonality among older prisoners which warrants a specific approach to their management. The MOD: Older Prisoners shows that the MoJ recognises this; indeed, it is inconsistent for them to have developed the MOD and yet not recognise the similarity of need among many older prisoners.**

122. **An ageing prison population creates specific pressures on the prison system. Currently, the response to these and the treatment of older prisoners is highly inconsistent across the prison estate. Though the Model for Operational Delivery: Older Prisoners contains useful operational guidance, it is not enough to address this inconsistency and ensure the prison system can properly respond to the needs of the older cohorts. *With the older prison population likely to rise further in the coming years, the MoJ should produce a national strategy for older prisoners. This strategy should encompass the provision of suitable accommodation for older prisoners, health and social care on the prison estate, and the release of older prisoners, including continuity of medical treatment or care in the community. It must also ensure that the resourcing and expansion of the prison estate is aligned to projections of the older prisoner population.***

297 Q148

Conclusions and recommendations

The older prisoner cohort

1. A clear definition of the older prisoner is necessary for establishing a more strategic approach to the cohort and the ageing prison population. We do not take a view on what that definition should be, but whatever age threshold is used should be based on firm evidence, and we encourage the MoJ to keep definitions used under review. Flexibility is also important, so that frail and vulnerable prisoners younger than any age threshold—50, 60, or otherwise—are managed in the most appropriate way. We also believe that prisoners need as far as is possible to be treated as individuals and receive regimes that are tailored accordingly. (Paragraph 8)

2. At the very least, older prisoners will remain a significant proportion of the prison population. It is likely that the size of the cohort will rise further after increases in police numbers and changes to sentencing come into effect. It is important that the size of the older prisoner population can be predicted as accurately as possible, so the prison system can prepare and be resourced most appropriately. *In its response to this report, the Government should publish updated projections for the ageing prison population for the next five years. These should factor in, as far as possible, the effects of its planned increases to police numbers and changes to sentencing policy.* (Paragraph 28)

Accommodation for older prisoners

3. It is welcome that the new prison places planned as part of the Government's expansion of the estate will be designed to better accommodate older prisoners and others with disabilities or limited mobility. However, the number of new places delivered under existing expansion projects has been limited. In addition, much of the existing prison estate is unsuited to the needs of older prisoners, and there is a substantial backlog of maintenance works. *We recommend that the long-term prison estate strategy in development specifically addresses the provision of reasonable adjustments and physical adaptations necessary to meeting the needs of the ageing population in existing prisons. In its response to this report, the Government should also update the Committee on the timeframe for publishing the long-term estate strategy in light of the Covid-19 pandemic, especially given the greater propensity of older people to contract the disease.* (Paragraph 38)

4. We are concerned that HMPPS is not consistently fulfilling its duties towards older and disabled prisoners, as required by the Equality Act 2010. These prisoners should not be housed in establishments where the physical design prevents them receiving equitable treatment. *In its response to this report, the Government should set out what processes are in place to ensure that older and disabled prisoners are accommodated in an appropriate setting.* (Paragraph 39)

5. It can be very difficult to accommodate some older individuals on the prison estate. Steps taken by some prisons to develop specific wings or units for older prisoners are welcome, though the variability of individual needs should be considered. *Good practice around the accommodation of older prisoners should be shared more widely.*

We recommend that all prisons housing a significant number of older prisoners designate appropriate accommodation for those with more complex health and care needs. We further recommend that the Ministry use the expansion of the prison estate to develop additional accommodation that is specifically adapted for older prisoners. The viability and cost of developing bespoke forms of custody for those with disabilities or nearing the end of their lives should also be explored. (Paragraph 45)

Regimes and activity for older prisoners

6. There needs to be greater recognition across the prison estate that some older prisoners will be unable to engage with the normal regime. Suitable activities and forums should be available to older prisoners to support their welfare and rehabilitation. We commend the excellent work done by some establishments, but provision of these is lacking in many prisons. *HMPPS should ensure that guidance and best practice on regime provisions for older prisoners is applied across the prison estate. We recommend that all prisons have a designated older prisoner lead, who can ensure that the older prison population has a voice and is managed most appropriately.* (Paragraph 55)

The health and social care of older prisoners

7. We praise prison staff, HMPPS and MoJ officials for their work in responding to the Covid-19 pandemic. The virus has brought into sharp relief many of the issues affecting the prison system, including the particular health vulnerabilities of older cohorts. *Amid the focus on protecting prisons from Coronavirus, HMPPS must continue to ensure that prisoners with existing health conditions are monitored and receive appropriate treatment and support.* (Paragraph 62)

8. An ageing prison population will increase pressure on prison healthcare. To ensure an equivalent standard of care as in the community, it is important that prison healthcare services are appropriately resourced, and staff have awareness of age-related health conditions. *We recommend that all prison healthcare teams have a designated older prisoner lead, and that training on age-related health-issues is available to all prison staff. The Government must also ensure that prison healthcare services are resourced in line with the needs of an older population.* (Paragraph 71)

9. Older prisoners are disproportionately affected by cancellations to external medical appointments, and their health can be seriously impacted by non-attendance. *While increasing the number and availability of prison staff to escort prisoners to appointments is important, we also recommend that the Government review increasing the use of telemedicine and other innovative ways to give prisoners access to medical advice.* (Paragraph 72)

10. The prevalence of dementia in prisons is poorly understood and prison staff can lack awareness of the condition. *All older prisoners should have access to screening services for dementia, and prison officers who work with older prisoners should receive training on recognising and managing its symptoms.* (Paragraph 76)

11. Continuing to incarcerate prisoners with severe dementia, who may no longer remember or understand why they are imprisoned, raises practical and ethical

considerations, especially as their condition is very difficult to manage on the prison estate. Equally, the Committee recognises that a significant element of this cohort are convicted for historic sexual offences. Particular attention must be given to the feelings of victims of such cases, both because of the nature of the offending itself and because of delays often experienced in bringing such perpetrators to justice. We recognise that some of those victims may consider that alternative custody arrangements and potential early release of some individuals risks adding to the suffering that they have already endured. This must be taken into consideration. *The Government should review whether alternative arrangements for housing prisoners with advanced dementia would be more appropriate in some circumstances.* (Paragraph 77)

12. An ageing prison population will increase demand for social care services in prisons. While the Care Act 2014 has brought some improvements, standards of provision are highly variable across the estate. A more strategic and coordinated approach is needed to improve consistency and ensure effective collaboration between prisons, local authorities and other organisation involved in delivering care. *In its response to this report, the Government should update the Committee on the progress of the action plan for social care in prisons in England and Wales, published following HMIP and the CQC's joint thematic report. The Government should also set out its plans for the future provision of social care in prisons* (Paragraph 87)

13. Peer support or 'buddy' schemes can be an effective way to help meet the care needs of older prisoners. We commend the good work done by some prisons in partnership with third sector organisations to develop such initiatives. *Prisons must ensure that prisoners providing care to other inmates are suitably trained and have appropriate oversight.* (Paragraph 90)

14. The ageing prison population has and will continue to increase the need for end-of-life and palliative care in prisons. We welcome the publication of the Dying Well in Custody Charter and the good practice at some establishments. But standards are not consistent across the estate. In addition, as mentioned previously, we recognise that there has been delay in providing justice for the victims of some prisoners. Again, attention must be given to the needs of the victims of those crimes. *The MoJ must ensure that provision of end-of-life and palliative care is properly resourced and coordinated to reflect the current and future needs of the prison population. The MoJ should also review whether, in certain circumstances, terminally ill prisoners nearing the end of their lives would be better cared for outside of the prison estate and how effectively current arrangements for compassionate release are operating in practice.* (Paragraph 96)

15. Prisoners applying for early release on compassionate grounds should have their applications processed in an efficient and timely manner. This is especially important for terminally ill prisoners near the end of their lives. *We recommend prisons identify a single member of staff to have overall responsibility for progressing an application for compassionate release.* (Paragraph 97)

The release and resettlement of older prisoners

16. Older prisoners can experience greater levels of institutionalisation and be less able to live independently following their release compared to younger cohorts. Many will require additional support to prepare them to re-join society. *Release programmes and guidance that are age relevant, focusing on issues such as using technology, finding accommodation, and accessing pensions and benefits, should be available to all older prisoners.* (Paragraph 102)

17. There is a shortage of suitable accommodation for older prisoners following their release, which can undermine their rehabilitation and prevent them from successfully re-integrating into society. We are particularly concerned about reports of older individuals being released to no-fixed abode. *With the older prison population likely to rise further, and the number of prison places set to increase, the Government must ensure that there is suitable provision of age-appropriate post-release accommodation, including housing for those with complex health or care needs.* (Paragraph 106)

18. Prisons, local authorities, and health and care providers do not always work together effectively to ensure continuity of older prisoners' health and social care. This can have a detrimental impact on an individual's health and their efforts to re-integrate into society. *The development of the new RECONNECT service is welcome, but we recommend that the Government implement further measures to promote integration between organisations involved in continuity of prisoners' health and social care.* (Paragraph 111)

19. We are concerned about reports of older prisoners being released without prescription medication or without being registered with a GP. *We recommend all older prisoners are supported to register with a GP prior to release; where a prisoner is unable to do so, they should be provided with guidance and formal ID so they are able to register once they are released into the community. We further recommend that HMPPS implement safeguards to ensure all prisoners are provided with any prescription medication on their release.* (Paragraph 112)

A national strategy for older prisoners

20. We disagree with the argument that older prisoners' needs are too wide-ranging to generalise. Though it is important to treat each prisoner as an individual, there is a commonality among older prisoners which warrants a specific approach to their management. The MOD: Older Prisoners shows that the MoJ recognises this; indeed, it is inconsistent for them to have developed the MOD and yet not recognise the similarity of need among many older prisoners. (Paragraph 121)

21. An ageing prison population creates specific pressures on the prison system. Currently, the response to these and the treatment of older prisoners is highly inconsistent across the prison estate. Though the Model for Operational Delivery: Older Prisoners contains useful operational guidance, it is not enough to address this inconsistency and ensure the prison system can properly respond to the needs of the older cohorts. *With the older prison population likely to rise further in the coming years, the MoJ should produce a national strategy for older prisoners. This strategy should encompass the provision of suitable accommodation for older prisoners, health*

and social care on the prison estate, and the release of older prisoners, including continuity of medical treatment or care in the community. It must also ensure that the resourcing and expansion of the prison estate is aligned to projections of the older prisoner population. (Paragraph 122)

Formal minutes

Wednesday 22 July 2020

Members present:

Sir Robert Neill, in the Chair

Paula Barker	Dr Kieran Mullan
Rob Butler	Andy Slaughter
Maria Eagle	

Draft Report (*Ageing prison population*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 122 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 8 September at 1.45 pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 21 April 2020

Professor Jennifer Shaw, Academic Lead, Offender Health Research Network; **Paul Grainge**, Chief Officer, RECOOP; **Emily McCarron**, Equality and Human Rights Policy Manager, Age UK — Q1–45

Peter Clarke, Chief Inspector, HM Inspectorate 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; **Dame Anne Owers**, National Chair, Independent Monitoring Boards — Q46–86

Tuesday 12 May 2020

Steve Bradford, Prison Group Director for the Women's Estate; **Graham Beck**, Governor, HMP Wymott; and **Alan Cropper**, Residential Governor and lead manager for work with older prisoners, HMP Wymott — Q87–140

Lucy Frazer QC MP, Minister of State, Ministry of Justice; **Dr Jo Farrar**, Chief Executive, HM Prison and Probation Service; **Kate Davies**, Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres, NHS England and NHS Improvement — Q141–176

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

AGE numbers are generated by the evidence processing system and so may not be complete.

Justice, Ageing prison population, Memo List

1 A former prisoner (AGE0005)

2 A former prisoner (AGE0006)

3 A serving prisoner (AGE0022)

4 Age UK (AGE0025)

5 Association of Directors of Adult Social Services (ADASS) (AGE0024)

6 BMA (AGE0033)

7 British Association for Counselling and Psychotherapy (AGE0011)

8 Care Quality Commission (AGE0038)

9 Catholic Bishops' Conference (AGE0004)

10 Clinks and RECOOP (AGE0018)

11 Criminal Justice Alliance (AGE0020)

12 De Profundis Ltd (AGE0001)

13 Dr Dennis Eady (AGE0008)

14 False Allegations Support Organisation (FASO) (AGE0023)

15 From the husband of a prisoner (AGE0029)

16 G4S (AGE0037)

17 HM Inspector of Prisons (AGE0039)

18 IMB HMP Wayland (AGE0009)

19 Independent Monitoring Boards (AGE0034)

20 Ministry of Justice, Department of Health and Social Care, Public Health England, NHS England (AGE0036)

21 NOTA (National Organisation for the Treatment of Abuse) (AGE0012)

22 Nuffield Trust (AGE0026)

23 Offender Health Research Network, University of Manchester (AGE0030)

24 Older People's Commissioner for Wales (AGE0007)

25 On behalf of a serving prisoner (AGE0016)

26 PPMI (AGE0010)

27 Prison Refrom Trust (AGE0021)

28 Robin Potter (AGE0003)

29 Royal College of General Practitioners (AGE0015)

30 Royal College of Speech and Lanuage Therapists (AGE0035)

31 Serco Ltd (AGE0028)

32 Soroptimist International Durham (AGE0014)

33 The Howard League for Penal Reform (AGE0013)

34 The Open University (AGE0031)

35 University of Huddersfield (AGE0019)

36 Women in Prison (AGE0027)

37 Prisons and Probation Ombudsman (AGE0042)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2019–21

First Report	Appointment of Chair of the Office for Legal Complaints	HC 224
Second Report	Sentencing Council consultation on changes to magistrates' court sentencing guidelines	HC 460
Third Report	Coronavirus (COVID-19): The impact on probation services	HC 461
Fourth Report	Coronavirus (COVID-19): The impact on prisons	HC 299
First Special Report	Prison Governance: Government Response to the Committee's First Report of Session 2019	HC 150
Second Special Report	Court and Tribunal Reforms: Government Response to the Committee's Second Report of Session 2019	HC 151
Third Special Report	Transforming Rehabilitation: Follow-up: Government Response to the Committee's Nineteenth Report of Session 2017–19	HC 152