House of Commons

Justice Committee

Older prisoners

Fifth Report of Session 2013–14

Volume I: Report, together with formal minutes, oral and written evidence

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The Justice Committee

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in a printed volume. Additional written evidence may be published on the internet only.

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The current staff of the Committee are Nick Walker (Clerk), Sarah Petit (Second Clerk), Gemma Buckland (Senior Committee Specialist), Helen Kinghorn (Committee Legal Specialist), Ana Ferreira (Senior Committee Assistant), Miguel Boo Fraga (Committee Assistant), Holly Knowles (Committee Support Assistant), George Margereson (Sandwich student), and Nick Davies (Committee Media Officer).

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Summary

Older prisoners are the fastest growing group within the prison population; the number of those aged over 60 grew by 120% and those aged 50–59 by 100% between 2002 and 2013. There are several reasons for this increase; partly prisoners are serving longer sentences, but more are now being convicted and sentenced to custody at an older age, including for historic offences that took place twenty or thirty years ago. Older prisoners are most likely to be serving sentences for sexual offences and this is reflected in the long sentences that they serve.

The health and social care needs of older prisoners are not all the same. It is broadly recognised that many prisoners have the biological characteristics of those who are ten years older than them; they may have chronic health and mental health disorders as well as disabilities which, in the community, would be typical among those who are significantly older. This is not the case amongst all older prisoners and there are many people who remain active and involved in the prison regime well into old age. We note the Government's view that it is not possible to generalise about the needs of older prisoners, but warn that this should not inhibit the identification of common features that can inform policy.

Disability and mobility needs are both severe and commonplace and in a prison estate that is designed to hold young, fit men, older prisoners risk being isolated by a physical environment and regime which they cannot access. NOMS have a responsibility to provide for adaptation to the physical environment, but we found that this is not universally being met. We recommend that older and disabled prisoners should no longer be held in institutions which are not able to meet their needs or are unsuitable environments. We also highlight some of the excellent regimes that have specific activities for older prisoners who do not, or cannot, work. The charity RECOOP has been commissioned by NOMS to help prisons to promote the wellbeing and involvement of older prisoners, and we recommend the expansion of similar services.

A lack of communication between prison staff and healthcare can contribute to delays in older prisoners accessing healthcare, and we found that the failure to connect IT systems between prisons themselves and the community has a tangible and negative impact on healthcare outcomes. We recommend that NOMS work with the NHS Commissioning Board to resolve this. We also recommend that prisons follow Department of Health guidelines and have a nurse lead for older prisoners.

The difficulties that older prisoners face in the physical environment have been exacerbated by social care that is described variously as variable, sparse and non-existent; there has been a deplorable absence of basic personal social care, for example for prisoners with serious mobility problems, and no one seems sure who has been responsible for its provision. We met some excellent prison officers and charity workers who are providing some of this essential social care but an ad hoc system means that too often older prisoners have to rely on the goodwill of officers and their fellow inmates to fulfil the most basic of

care needs. We welcome the Government's clarification in the Care Bill that statutory responsibility to provide for social care will lie with the local authority in which a prison is located, but we note that it is not a guarantee of effective outcomes and work needs to be done to ensure that prisons work well with local authorities. We recommend that NOMS should set out the minimum standards of care that it expects and consider placing social workers in prisons to work with older prisoners.

In relation to provision of end of life care, we find that some prisons have developed effective palliative care suites which allow prisoners to die with dignity, while others chose to die in their cells or in hospital. We recommend that new guidelines on the use of restraint in end of life care should give confidence to prison officers in taking compassionate decisions in clinical environments. Release on compassionate grounds is a difficult decision for Governors and in some cases for Ministers, but some prisons are not able to effectively provide end of life care; we recommend that Governors consider the ability of their prisons to provide effective care in considering release on compassionate grounds.

The resettlement needs of older prisoners are different from the rest of the prison population; taken as a category and with some exceptions, they are the least likely group to reoffend and they are unlikely to gain employment. Many basic skills, such as accessing community services and living independently, are critical for successful reintegration. We found that there is real difficulty in finding accommodation for older prisoners on release, with many going to approved premises, but some being released to No Fixed Abode. We recommend that England should adopt the practice in Wales where no prisoner may be released without accommodation.

Older prisoners have needs that are distinct from the rest of the prison population by virtue of their severity and there is marked commonality between groups of older prisoners. We recommend that the growth in the older prisoner population, which is likely to continue, and the severity of their needs warrant the creation of a national strategy to remove inequity of provision and maintain minimum standards.

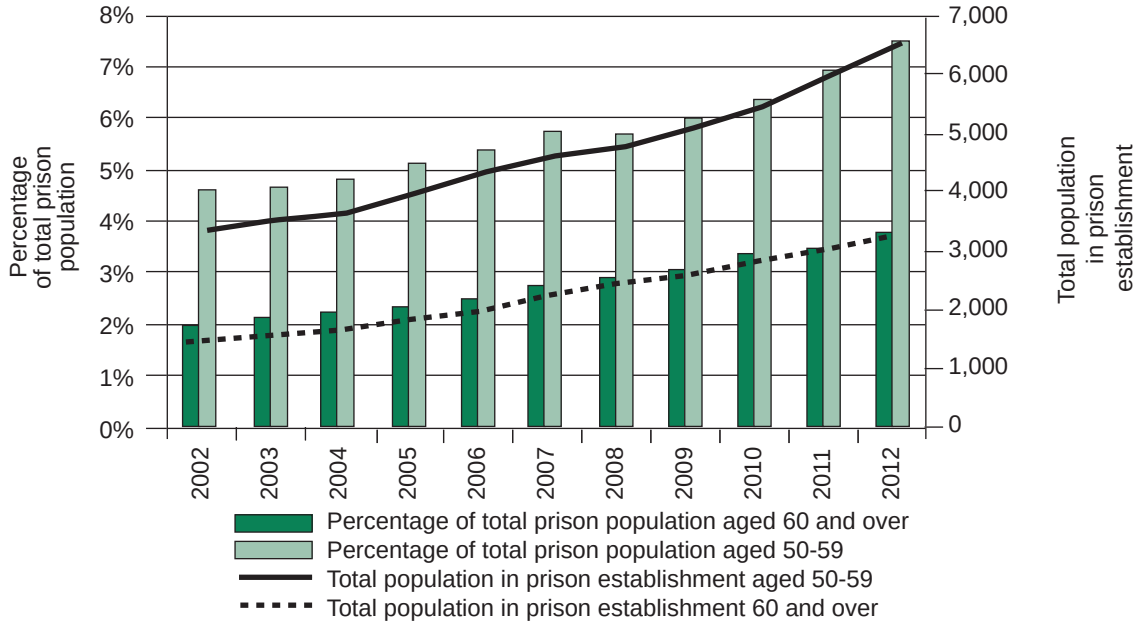
In this Report recommendations are set out in **bold text** and conclusions are set out in ***bold italics***

1 The characteristics of the older prisoner

Background to the Committee's inquiry

1. Those aged over 60 and those aged 50–59 are respectively the first and second fastest growing age groups in the prison population; between 2002 and 2013 there was an increase of 120% and 100% in the number of prisoners held in those age groups respectively.[1] They are growing both in absolute terms and as a proportion of the total prison population, as shown below in Chart I. In 2004 HM Inspectorate of Prisons produced a thematic report titled *No problems: old and quiet* which criticised the lack of care of older prisoners; in 2008 HMIP conducted a follow up report that reiterated many of the criticisms from 2004. They found that while good practice of care of older prisons existed, the National Offender Management Service and prisons themselves did not take the special needs of older prisoners seriously. They found that the older a prisoner, the more barriers there were to active life, the greater their mental and physical health needs, and the less likely it was that they would be able to live and function in dignity. Some had become wholly disengaged from staff and other prisoners, as a consequence of physical or intellectual degeneration, or mental health problems.[2] This inquiry draws on many of the findings of those reports and explores how provision stands now.

Chart I: Rise in older prisoner population



Data source: Ministry of Justice: Table A1.4, Offender Management Caseload Statistics, 2012 tables, www.gov.uk

1 *Meeting the needs of older prisoners,* Standard Note SN03630, House of Commons Library, May 2013

2 HM Inspectorate of Prisons, *'No problems: Old and Quiet': Older prisoners in England and Wales,* September 2004

2. In view of the increase in the older prisoner population and the concerns expressed by HMIP we launched an inquiry into older prisoners. Specifically the inquiry asked for evidence in the following areas:

i. Whether responsibilities for the mental and physical health and social care of older prisoners are clearly defined.

ii. The effectiveness with which the particular needs of older prisoners including health and social care, are met; and examples of good practice.

iii. What environment and prison regime is most appropriate for older prisoners and what barriers there are to achieving this.

iv. The effectiveness of training given to prison staff to deal with the particular needs of older prisoners, including mental illness and palliative care.

v. The role of the voluntary and community sector and private sector in the provision of care for older people in leaving prison.

vi. The effectiveness of arrangements for resettlement of older prisoners.

vii. Whether the treatment of older prisoners complies with equality and human rights legislation.

viii. Whether a national strategy for the treatment of older prisoners should be established; and if so what it should contain.

3. We received 43 submissions of written evidence from the Ministry of Justice, bodies that monitor prison standards, organisations that work with older prisoners, organisations that represent professionals, academics and advocacy groups, as well as older prisoners and their families. We also took oral evidence from Nick Hardwick, HM Chief Inspector of Prisons; Peter McParlin, National Chairman of the Prison Officers Association; Nigel Newcomen, Prisons and Probation Ombudsman; Helen Boothman, Secretary of the Association of Members of Independent Monitoring Boards; Sean Humber, Partner at Leigh Day; Dr Azrini Wahidin, Reader in Criminology and Criminal Justice, Queen's University Belfast; Dr Seena Fazel, Royal College of Psychiatrists; Dr Iain Brew, Royal College of General Practitioners; Professor Jennifer Shaw, the Offender Health Research Network; Paul Grainge, Lead Capacity Building Consultant, RECOOP; Dr Stuart Ware, Director of Restore Support Network; Gill Walker, Chair of the Older People in Prison Forum, Age UK; Michael Spurr, Chief Executive, National Offender Management Service; Bruce Calderwood, Director, Mental Health, Disability and Equality, Department of Health; and Jeremy Wright MP, Minister for Prisons and Rehabilitation.

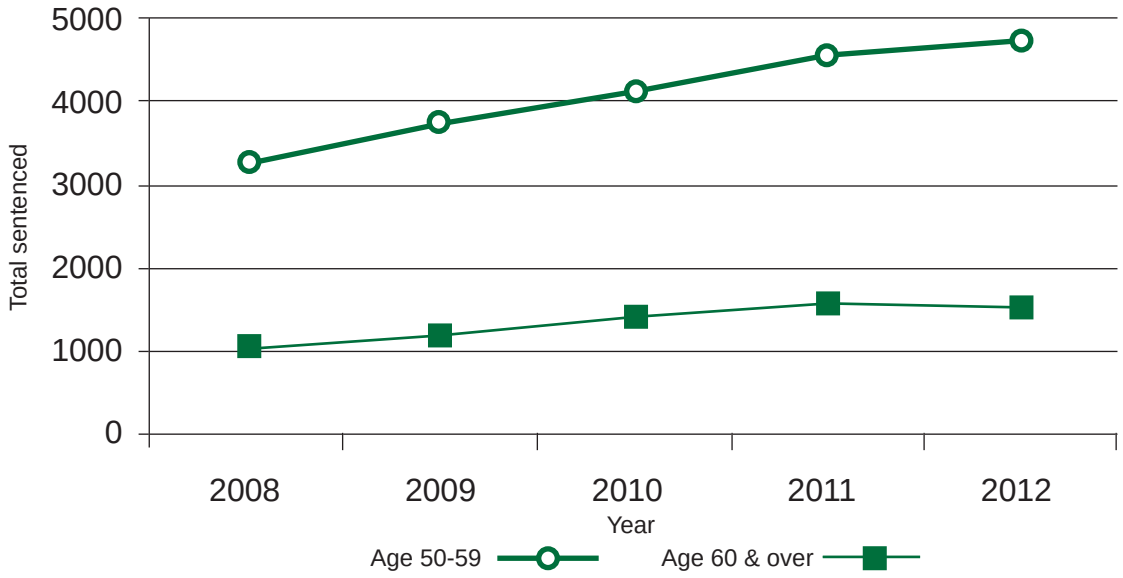
4. When we launched this inquiry, we decided to use the age of 60 or more to define an older prisoner. We are aware that some argue that prisoners above the age of 50 should be included in this category, and some evidence that we received put this case forward. In this section we consider the profile of the older prisoner population. We also explore whether one can consider the older prison population as a homogeneous group; do the old in prison have similar characteristics or is it possible to distinguish between groups? In considering how an older prisoner might be defined, we explore the health and mental health problems that are typically faced by both those within the younger 50 to 59

demographic and those over the age of 60. We consider the social care needs of these prisoners and issues of disability.

The older prisoner population

5. At the end of March 2013 there were 6,639 prisoners in England and Wales who were aged between 50 and 59 and there were 3,381 over the age of 60.[3] This accounts for around 8% and 4% of the total prison population respectively.[4] The causes of the growth in the older prisoner population are varied, with some evidence pointing to an ageing society and an increase in the lengths of sentences served by offenders. Prisoners aged 50–59 and over 60 are frequently serving sentences for sexual offences; as of 30 June 2012, 33% of 50–59 year old males and 58% of males over the age of 60 were in prison following sentences to immediate custody after conviction for sexual offences.[5] The increase in the total prison population may in part be caused by the broader increase in convictions for sexual offences; from 2002 to 2012 there was an increase of 45%.[6] The number of people convicted at an older age has also increased; chart II shows that between 2008 and 2012 there was an increase in the number of people convicted to immediate custody aged 50–59 of 45% and an increase of 46% in the number aged 60 and over.

Chart II: Number of defendants aged 50 and over sentenced to immediate custody



Data source: Information provided by Ministry of Justice at the request of the Committee

3 Ministry of Justice, *Offender Caseload Management Statistics*, Prison population tables March 2013, Table 1.8

4 *Ibid.*

5 Ministry of Justice, *Annual tables - Offender Caseload Management Statistics 2012*, Population Statistics, Table A1.7

6 This includes convictions for both men and women. The number increased from 4111 convictions for sexual offences in the year to March 2002 to 5951 in the year to March 2012, an increase of 45%. Source: Ministry of Justice, *Criminal Justice Statistics England and Wales*, Conviction Tables March 2012, Table Q4a

What constitutes an older prisoner?

6. The National Offender Management Service (NOMS) and the Government do not use any particular age to define an older prisoner, and do not consider it to be a particular demographic group in the same way as they do young, or women, prisoners. In its submission to this inquiry, the Ministry of Justice recognise that there is considerable academic and practical debate with regard to the age at which a prisoner is considered old. Their submission refers to both the 50–59 age group and to those over 60.

> It is frequently argued that, because of the earlier onset of a range of health problems amongst the offender population, the term older prisoners should be used to refer to those aged 50 and over. If that definition is applied, there were 9,727 prisoners (over 11% of the total population) in the category.[7]

7. In the UK and abroad a variety of ages are used to define older prisoners. Dr Azrini Wahidin in written evidence, for example, told us:

> The American Department of Justice and older units for older prisoners in the UK and in the States have used the age 50–55 as the threshold age to define when one becomes an older offender. Aday (1994), conducted a national survey of State prison departments and found that 50 years of age was the most common criterion for old age that prison officials utilise. Similarly, Wahidin (2002, 2004) found in a national study of men and women who are over 50 in prison in the UK that prison officers, healthcare personnel and governors running older units, defined older offenders as 50 and over.[8]

8. Charities and advocacy groups that submitted evidence to us were unanimously of the opinion that older prisoners should be defined as those over 50. RECOOP, Age UK and the Restore Support Network all advocated in their written and oral evidence that there should be recognition across the prison service that those aged over 50 should be considered a unique demographic.[9] The Prison Reform Trust used 50 as a benchmark for old age in the research that informed their submission and their report into good practice in the provision of services for older prisoners. They listed the following reasons for using the definition:

- Some older prisoners have a physical health status of 10 years older than their contemporaries in the community. This can be due to a previous chaotic lifestyle, sometimes involving addictions and/or homelessness.
- Fifty is used in NHS healthcare, and services for healthy ageing start at this age.
- Age UK and other organisations working with older people start their services at fifty.

7 Ev 73

8 Ev 38

9 Ev 55 [RECOOP], Ev 77 [Age UK], Ev 66 [Restore Support Network]

- Changes in national demographics and numbers sentenced mean that the prison service will have to work with people on their preparation for old age, and on preventative health measures, so policies need to be in place before people need support and/or reach later old age.[10]

For the purposes of inspection, HM Inspectorate of Prisons (HMIP) define older prisoners as those aged 50 and over:

> This is because research suggests that using 50 years of age as a cut-off recognises that people age quicker while in prison; by up to 10 years more than their biological age prisoners age.[11]

9. Not all share the view that those aged over 50 should be defined as an older prisoner. Dr Elaine Crawley, Reader in Criminology and Director of Salford University's Centre for Prison Studies pointed to her experience in written evidence to us:

> In my own view, however, our retirement age for men (65 years) is the age at which most people, both within and outside the prison community are starting to 'feel old'. I do not accept the generally held view that prisoners are generally 10 years older, both physically and mentally, than his counterpart in wider society. This was not borne out during my research: rather people from all walks of life age differently. The 'older' prisoners I have interviewed in the period 2002 to the present have been aged between 65 years and 84 years.[12]

The health and social care needs of older prisoners

10. Information with regard to the health, mental health and mobility needs of older prisoners is not centrally collected by the Ministry of Justice or the National Offender Management Service. It is, therefore, difficult to establish the profile of chronic needs of the older prisoner demographic. However, research conducted over the last ten years can give us a good indication. This Report will explore the provision of healthcare for older prisoners up to this point in Chapter 3.

Physical health needs

11. In 2001 Dr Seena Fazel from the Royal Society of Psychiatrists, who gave oral evidence to us, and others conducted a study into the healthcare needs of prisoners over the age of 60 who were held within prisons within 100 miles of Oxford. The research found that there were startling levels of chronic health needs; 85% of the group had one or more major illness reported in their medical records. The most common illnesses found in this study are set out in the table below.

10 Prison Reform Trust, 2010, *Doing Time: Good practice with older people in prison – the views of staff,* www.prisonreformtrust.org,uk

11 Ev 41 [HM Chief Inspector of Prisons]

12 Ev w28 *[Note: references to 'Ev wXX' are references to written evidence in the volume of additional written evidence published on the Committee's website]*

12. A comparable study, of prisoners over 60 in the North West Prison Service Area, conducted by Professor Jenny Shaw, from the Offender Health Research Network, and others in 2011 found similarly high rates of chronic illness; 80% of those aged 60–64 had at least one moderate or severe disorder; so did 91% of those aged 65–69; and 92% of those over the age of 70. The study found that the most common disorders were similar to the 2001 study and also suggested that there were significant hearing and eyesight problems amongst older prisoners. The study also found similarly high results of chronic disorders among the 50–59 demographic; 71% of 50–54 years old had a moderate or severe disorder and 77% of those aged 55–59. The only common physical disorders that were substantially less frequently experienced by the younger demographics were genitourinary, and hearing and eyesight disorders. The proportion of older prisoners who are taking prescribed medication is also far higher than the younger cohorts; 70% of older prisoners reported to HMIP that they are taking medication compared with 44% of the prison population as a whole.[13]

Table 1: Proportion of prisoners over 60 with most prominent chronic physical health disorders

Disorder	Fazel, et al: 2001	Hayes, et al: 2012	
		60–64	65–69
Cardiovascular	35%	51%	55%
Musculoskeletal	24%	51%	66%
Respiratory	15%	27%	36%

Data source: 2001 column uses: Fazel, S., Hope, T., O'Donnell,I., Piper, M., Jacoby,R., 2001, Health of elderly male prisoners: worse than the general population worse than younger prisoners, Age and ageing, 300, pp. 403–407; and 2012 column uses: Hayes, A., Burns, A., Turnball, P., Shaw, J., 2012, The health and social needs of older male prisoners, International Journal of Geriatric Psychiatry,27, pp.1155–1162

Mental health

13. With regard to mental health Dr Fazel et al. found that 45% of over 60s had a psychiatric disorder. This is similar to the later research which showed a prevalence of 54% of those aged 60–64; 39% aged 65–69; and 67% of those aged over 70. The rates of mental disorders are, however, significantly higher in those aged 50–59; 90% of those aged 50–54 and 77% of those aged 55–59 were found to have a mental disorder. Anxiety, substance misuse, alcohol misuse and drug misuse and major depressive disorders were more prevalent in the younger cohort than those over the age of 60. [14] This prevalence of mental disorders reflected a study conducted in HMP Stafford that found that 51% of 50–59 year olds had at least one diagnosable psychiatric disorder and 42% of those over 60.[15] In research into the psychiatric needs of older prisoners, Dr Fazel and colleagues' survey

13 Ev 41 [HM Chief Inspector of Prisons]

14 *Ibid.*

15 Le Mesurier, N., Kinston, P., Heath, L., Wardle, S.,2010, *A Critical Analysis of the Mental Health Needs of Older Prisoners: Final Report*, South Staffordshire Primary Care Trust and Staffordshire University

found that 53% had at least one diagnosable psychiatric condition, and 30% had depression, including 17% who had experienced a major depressive episode. According to the British Psychological Society these figures are much higher than those found in comparable populations in the community.[16] Dr Fazel confirmed this notion in oral evidence to us:

> If you look at surveys of other people in the community of a similar age, you tend to find 20%, 30%, 40% [have a chronic physical health problem]; so you do find some disparity in physical health problems. The same thing has been found in the US, where there are two or three quite good and large surveys of physical health problems.[17]

14. In respect of differences between the mental health profile of older prisoners and older people in general, Dr Fazel noted in evidence to us that:

> In terms of rates of mental illness, the particular mental illness that differs is depression. Rates of depression in older prisoners are probably about three times higher than the equivalent age and gender equivalent person in the community.[18]

This reflects HM Inspectorate of Prisons findings in their thematic review on older prisoners in 2004 which suggested that of those who had mental health problems, 78% were experiencing depression or reactive depression as a result of imprisonment.[19]

15. It seems to be particularly difficult accurately to establish rates of dementia; this may partly be to do with the fact that there is a lack of training and understanding of dementia which could limit its diagnosis, but also because of the nature of the disease. Some estimates suggest that rates of dementia among older prisoners are as high as 5% (among those over 55)[20] while others suggest it is around 1%—a comparable rate to the community.[21] This is supported by evidence from the Royal College of Psychiatrists that dementia in prisons is rare.[22] On an anecdotal level, Dr Iain Brew, a general practitioner at HMP Leeds, reported that he does experience prisoners with dementia.

> We diagnose dementia not infrequently, but I am sure there are cases that are going under our radar because we are not specialists in that field.[23]

Jeremy Wright MP, the Minister for Prisons and Rehabilitation, however, recognised that rates of dementia in prisons were likely to increase with the proliferation of the older prisoner population.

16 Ev w17

17 Q 67 [Dr Seena Fazel]

18 Q 71 [Dr Seena Fazel]

19 HM Inspectorate of Prisons, *No problems: Old and Quiet: Older prisoners in England and Wales,* September 2004

20 Ev 55 [RECOOP]

21 Q 71 [Dr Seena Fazel]

22 Ev 65

23 Q 71 [Dr Iain Brew]

> I agree entirely with you that dementia is one of those things that we must always be conscious of in any environment in which older people are located. Prison is increasingly going to be one of those.[24]

Rates of disability and mobility restrictions

16. Ministry of Justice research suggests that in a sample of the total prison population 36% serving sentences between one month and four years were classified as presenting a form of disability; this compares with rates of disability of 20% of men and 18% of women across all age groups in the community.[25] The definition of disability used is broad and uses the Equalities Act 2010 and the Disability Discrimination Act 1995 (DDA) to include physical disability as well as anxiety and depression.[26] A higher proportion of older prisoners were classified as being disabled; 50% of prisoners over the age of 40 compared to 42% of 30–39 year olds, 32% of 21–29 year olds, and 18% of 18–20 year olds. HMIP found in their thematic report into disabled prisoners that a more conservative 37% of those over the age of 50 had a disability which accounted for a total of 21% of the total population of disabled prisoners.[27] Older prisoners account for a significantly higher proportion of the disabled in prison than the proportion they account for in the total prison population.[28]

17. The typical needs of disabled prisoners do not seem to differ from those of the disabled in the community. However, the particular needs that relate to mobility were frequently cited in evidence to us. Access to different parts of the prison and to work and activities requires either adjustments to the environment or provision of mobility aids such as walking sticks or wheelchairs. Prisoners with mobility needs may also require regular social care to carry out essential personal activities; these needs are as varied as help in carrying their meals, to maintenance of their cells, to help in washing themselves. On our visits to both HMP Dartmoor and HMP Isle of Wight we saw the extent to which this support was required by the older prisoners that we met. Older prisoners frequently commented to us on their difficulty in climbing stairs in prison wings which were as high as four floors. Examples were given in evidence to us:

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24 Q 133 [Jeremy Wright MP]

25 Office for National Statistics, *Family Resources Survey 2010/11*, June 2012, p. 80

26 Ministry of Justice Analytical Services, 2012, *Estimating the prevalence of disability amongst prisoners: results from the Surveying Prisoner Crime Reduction survey*, Research Summary 4/12. Prisoners were considered to have a physical disability if they reported having the following conditions; difficulty in seeing; difficulty in hearing; learning difficulties; epilepsy; cancer; HIV/AIDS; neurological disorder. Also included were those who reported having poor or very poor health as well as the following; problems with arms, legs, hands, feet, back or neck; skin conditions; chest, breathing problem, asthma, bronchitis; heart, blood pressure, or blood circulation problems; stomach, liver, kidney or digestive problems; diabetes. Those with drug or alcohol addictions were not included. This survey only includes prisoners sentenced to between one month and four years in prison.

27 HM Inspectorate of Prisons, 2009, *Thematic Report, Disabled Prisoners;* Differences between the Ministry of Justice and HMIP survey results of disabilities may be because of the nature of survey differentiation; a different definition of the scope of disability; the different years in which survey was taken. It is also important to note that the HMIP includes the whole prison population, while the MoJ survey only include sentenced prisoners serving between one month and 4 years. Both surveys use self reporting methods.

28 In the assessment of disability in prison, HMIP uses the definition prescribed under the Disability Discrimination Act 2005. The following constitute a disability: physical and motor impairments; progressive conditions such as cancer, HIV or multiple sclerosis; visual impairments; mental impairments; deafness and hearing impairments; learning disabilities and difficulties; speech and language impairments; disfigurement.

> "I only go to the over-50s when I can get there, as I am disabled and on crutches all the time."([Prisoner] Age 75)[29]

> Two Physiotherapists came into examine me. They tested me on a stairs and said that I could use them but to go slowly and take my time. They also tested me going out to the exercise yard. Again they said I could use the yard but to go easy.[30]

Accelerated Ageing

18. Accelerated ageing is frequently cited as the key justification for including 50 to 59 year olds in the older prisoner definition. Much oral and written evidence we received argued that many prisoners in their 50s have health and mobility problems that would be expected of much older people in the community. The causes of this acceleration are twofold: chaotic and unhealthy lifestyles prior to entering prison, and the experience of imprisonment speeding the ageing process in terms of physical and mental health.[31] Dr Azrini Wahidin, who gave oral evidence to this inquiry, conducted extensive research into the issue and the principle has become established to the extent that it is recognised by HM Inspectorate of Prisons.[32]

19. Not all accept the phenomenon of accelerated ageing.[33] It is also possible that access to healthcare and mental healthcare in the prison environment may mitigate the impact of accelerated ageing. Evidence we received pointed to the fact that for some people prison is their first engagement with healthcare services. Professor Jennifer Shaw commented:

> We did a study not specifically on older prisoners looking at what happens to mental health as you go through prison. What we found, interestingly, was that all types of mental health problems improved in prison[...] There were significant improvements in people's mental health in prison. We put that down to the fact that people often live quite chaotic lives in the community, but when they come into prison they have some stability and healthcare—perhaps for the first time—and, therefore, their mental health improved.[34]

Distinguishing between groups of older prisoners

20. While it is clear that many older prisoners share similar characteristics and needs, other evidence queried whether it was possible or useful to define them as a homogeneous group. The Prisoners Education Trust, for example, do not see value in holding a single definition of what constitutes an older prisoner. In relation to education they said:

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29 Ev w34 [Prisoners Education Trust]

30 Ev w4 [Prisoner F]

31 Ev w23 [Louise Ridley and Charlotte Bilby]

32 Ev 38

33 Spaulding, A., Seals, R., McCallum, V., et al., 2011, Prisoner survival inside and outside of the institution: implications for health-care planning, *American Journal of Epidemiology,*173, pp. 479–487

34 Q 72

> While it is sensible to understand that they may have particular needs as a distinct demographic within the prison, older prisoners should not be dismissed as quiet or incapable. Many are highly skilled and capable of pursuing learning with little assistance.[35]

21. The Ministry of Justice argued that it was not possible to define older prisoners as a single group with homogeneous needs. In oral evidence the Minister for Prisons and Rehabilitation, said that it would not be possible to articulate a set of needs for a group that bears disparate characteristics:

> It seems to me very clear that older prisoners are not one uniform group about whom we can have a sensible set of criteria [...] There is huge variation. Depending partly on how you categorise an older prisoner—some categorisations say over 50 and some say over 60—you can imagine that, even if you are talking about the over-60s, there is huge variation in the nature of those individuals, and therefore finding something that is consistent and equally applicable to say about all offenders and prisoners who are over that age would be very difficult.[36]

22. On our visits to HMP Dartmoor and HMP Isle of Wight, we met prisoners who were near to or older than 70 who were active, mobile and articulate; we also met prisoners who were much younger but had very limited mobility and reported severe health needs that would not have been typical for their age group in the community.

Convictions for historic sexual offences

23. The increase in the older prisoner population has been partly driven by an increase in convictions for historic sexual offences. There has been a dramatic increase of 45% in the number of people convicted for sexual offences between 2002 and 2012.[37] The Ministry of Justice does not collect statistics for the conviction for historic offences but written evidence frequently referred to this factor and prisoners believed it chimed with their experiences:

> This prison [HMP Dartmoor] is being turned into the V.P. unit (vulnerable person) of the south-west. It is fast filling up with elderly men, due to "Historic Cases".[38]

> Many elderly prisoners are in prison for historic offences that happened, say, 30 years ago. During that 30 years the prisoner has lived a crime free life.[39]

24. Staff and prisoners at both Dartmoor and Isle of Wight remarked to us that they have seen a notable increase in prisoners serving sentences for historic offences. Dr Elaine Crawley in her written evidence said:

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35 Ev w34

36 Q 118 [Jeremy Wright MP]

37 Ministry of Justice, *Criminal Justice Statistics England and Wales*, Conviction Tables March 2012, Table Q4a; this information includes convictions, not all of which will result in immediate custody.

38 Ev w1 [Prisoner A]

39 Ev w1 [Prisoner B]

> I did not expect to find so many elderly men serving relatively long sentences for "historic" offences (usually—but not in every case—sexual offences allegedly carried out up to five decades ago).[40]

25. This trend is likely to continue. The Director for Public Prosecutions announced in March 2013 that the Crown Prosecution Service will engage in a new drive to increase the number of convictions for child sexual abuse.[41] This group of prisoners is different from the traditional older prisoner population. As Dr Brew told us:

> Yes, there are two populations. There is the prison population who have been in and out over many decades and have aged through the criminal justice system, as it were, and then, as you quite rightly say, there are people who have been living relatively normal lives and come in later. Both groups exist; there is no doubt about that, and I see them on a daily basis. Increasingly, over the last decade or so, you are absolutely right—there are people who are coming to justice many years after their offences, but they also bring in a number of health problems in the same way. It is important to bear in mind the two types of older prisoner.[42]

Categorisation of older prisoners

26. Dr Jen Geary, in her written evidence, builds on recommendations by the American Civil Liberties Union and suggests that there are three main groups of older prisoners. Her suggestions reflect our understanding of the groups of older prisoners that exist in England and Wales.[43]

a) Those who committed serious or violent crimes at a younger age and sentenced to a long stay in prison during which time they have become old.

b) Chronic and repeat offenders who have been repeatedly imprisoned throughout their lives.

c) Those who have been convicted for historic offences, frequently sexual offences, later in life a long time after the offence took place.

27. **We consider that it does not make sense to impose a rigid classification of age, whether over 50, over 60, or over 65 in defining the older prisoner population. We also note the Ministry of Justice's view that it is not possible to generalise about the older prisoner population. However, the duty to treat each prisoner as an individual should not inhibit the identification of common features among the older prisoner population that can inform policy. Otherwise, the needs of older prisoners will continue to be overlooked.**

40 Ev w28

41 Keir Starmer QC, Director of Public Prosecutions, *The criminal justice response to child sexual abuse: time for a national consensus*, Speech on 6 March 2013, www.cps.gov.uk

42 Q 69

43 Ev w10

2 Suitability of the prison estate and regimes

28. Some of those who submitted evidence to us questioned whether the prison estate is suited or prepared to hold older prisoners. The Criminal Justice Alliance argued that prison was not appropriate for many older prisoners, particularly those who did not pose any risk of harm to the public and those whose health and social care needs could be more effectively met in the community.[44] However, many older prisoners have been given custodial sentences for public protection or because of the gravity of their offences and there are serious concerns that the prison estate and prison regimes can fail to provide adequate conditions and exclude older prisoners from full involvement and leave them isolated from the rest of the prison population. One particularly serious example was found by HM Inspectorate of Prisons at HMP Winchester:

> Two older, severely disabled men who shared a small cell, built by the Victorians for one, were not untypical. [...] Neither man was able to work so they spent 23.5 hours a day in their cell. Although there was a shower on the landing, it had not been adapted for use by people with disabilities and so they were unable to use it. Neither had had a shower for months but did their best to wash in their cell. They relied on other prisoners for help with tasks such as collecting meals. Wing staff were unaware of these problems when we brought them to their attention.[45]

A suitable environment for older prisoners

29. The fabric and condition of the prison estate is known to vary wildly. Evidence to us indicates that while an environment which is appropriate to older prisoners has been facilitated in modern prisons, it simply does not exist in older prisons. The Ministry of Justice acknowledge that the newer parts of the prison estate are more suited to older prisoners than the old. [46] The Minister admitted to us that elements of the estate are not suited to older prisoners:

> Most of our prisons will have the capacity to accommodate people with mobility problems, but, as you rightly say, some of the older prisons are more challenging than some of the newer ones.[47]

30. Typically, among the cohort of older prisoners there will be those who require an environment that is suitable to wheelchair users, including ramps and doors wide enough for the wheelchair; handles in particular locations to lift themselves; showers and toilets that are suited to disabled people; easy and regular access to toilets because of incontinence; easy access to other parts of the prison, including healthcare and education departments; the minimum use of stairs.

44 Ev w14

45 HM Chief Inspector of Prisons, *Report on an unannounced inspection of HMP Winchester,* March 2013, p. 6

46 Ev 73

47 Q 120

31. The National Offender Management Service is required to promote equality and eliminate unlawful discrimination in all prisons in England and Wales under the Disability Discrimination Act 2005. Disability, as defined in the Act, covers a range of impairments, both physical and mental, including learning disability.[48] The responsibility to adapt the prison environment so that it suits less able prisoners clearly lies with a prison's senior management team and NOMS more broadly. Prison Service Instruction 32/2011 states that "Governors must consider whether prison policies and practices, the built environment, or lack of auxiliary aids and services could put a disabled prisoner at a substantial disadvantage and if so must make reasonable adjustments to avoid the disadvantage".[49] Michael Spurr agreed that NOMS had responsibility to make such arrangements.[50]

32. Some of these requirements can easily be met by the prison estate. A simple measure is to avoid placing older prisoners in bunk beds; we found in Isle of Wight that older prisoners had serious difficulty accessing and getting themselves out from both top and bottom bunks. The IMB at HMP Wymott agreed with this finding.

> [...] bunk beds are considered by the Board to be totally unsuitable for elderly, and often, infirm or weak prisoners and present a potentially serious health and safety issue. Some bunk beds have no access ladder. One prisoner stated that he accesses his top bunk `by standing on a chair'.[51]

Prisoners are often—though not always as we explore below—provided with functional tools to aid them in their independence. Typically walking aids and wheelchairs are provided to make the prison environment more feasible, as are grab rail in showers, toilets and in wings. At the Isle of Wight we learnt that older prisoners are sometimes given chairs with sufficient back support to allow them to conduct work comfortably in their cells. Moreover prisoners with limited mobility, and particularly those who are in wheelchairs, were given particular preference for ground floor cells at HMP Dartmoor.

33. Some of the problems faced by older prisoners require more substantive and structural changes. Examples of this include installing lifts or stair lifts, widening doors for wheelchairs and more broadly assuring that the whole prison is accessible to the disabled and less able. This kind of adaptation to suit the aging prison population has not universally occurred, nor in some cases is it able to occur. [52] HMP Dartmoor cells were not big enough, nor doors wide enough to enable wheelchair access. Prisoners also noted, in submissions to us, difficulty in moving around the prison.

> Being in a wheelchair as I am, [HMP Dartmoor] is particularly bad: the education bloc [can] only be accessed via a multi-flight, outside fire escape.[53]

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48 Ev w34 [Prisoner Education Trust]

49 Ev 77 [Age UK]

50 Q 122 [Michael Spurr]

51 Ev 60 [Association of Members of Independent Monitoring Boards]

52 HM Inspectorate of Prisons, *'No problems: Old and Quiet': Older prisoners in England and Wales,* September 2004, p.3; HM Chief Inspector of Prisons, *Older prisoners in England and Wales: a follow up to the 2004 thematic review,* June 2008, p.18

53 Ev w1 [Prisoner A]

We found that adaption to meet the needs of the disabled could not be conducted because HMP Dartmoor is a listed building, yet a high number of older prisoners with wheelchairs were held there. The Independent Monitoring Board at HMP Coldingley reported a similar situation.

> Coldingley's industrial role is likely to limit its ability to accommodate many older prisoners, and 80% of its accommodation—in the four original wings— cannot readily be adapted to the needs of older prisoners.[54]

34. The Ministry of Justice told us in evidence that "work is at an early stage to consider how a strategic approach to the use of the prison estate can best ensure that older offenders are accommodated where their needs can best be met, and where the built environment can facilitate this".[55]

35. ***While some prisons are making substantial efforts to adapt their facilities to meet older prisoners' needs, NOMS' responsibility to provide for adaptation to the physical environment of the prison to make basic living for older prisoners feasible is not universally met. In some cases it is impossible to make the necessary adaptations.*** **We recommend that NOMS should conduct a comprehensive analysis of prisons' physical compliance with disability discrimination and age equality laws. As part of the ongoing changes to the prison estate, NOMS should determine which prisons simply are not able to make the adaptation necessary to hold older prisoners and it should then no longer hold older or disabled prisoners in these institutions.**

Allocation to a prison

36. High security and category C working prisons are the most likely setting in which older prisoners are held; many older prisoners who are sex offenders are considered to be high risk and so are categorised accordingly. Moreover many older prisoners are considered to be vulnerable and are therefore co-located. High security and category C prisons that hold longer term and life sentence prisoners at different stages of their sentence have a higher percentage of older prisoners. In some cases up to 15% of inmates are 60 and over.[56] The Prison Reform Trust suggest that these factors had resulted in the accumulation of older people in particular prisons. Both HMP Isle of Wight and Dartmoor are examples of this; at the time of our visit there were 435 prisoners over the age of 50 at HMP Isle of Wight, 173 over the age of 60 and 106 over 65. 70% of these are serving long sentences.

37. Many older prisoners do not believe the risk they pose of escape warrants incarceration in the high security estate. Older prisoners at HMP Isle of Wight, a category B prison, claimed that their frailty and lack of unaided mobility would not allow them to attempt escape, and that high security detention of such individuals was therefore a waste.

38. Michael Spurr, the Chief Executive of NOMS, did not agree that increased age inevitably led to a reduction in the risk which a prisoner bears. He told us that the only

54 Ev 60

55 Ev 73

56 Ev w23

escape from a prison in the last 12 months was by a man over the age of 60 who scaled HMP Pentonville's wall; the individual had, moreover, been in custody for a long time.[57]

39. We asked the Minister what consideration is given to the appropriateness of a setting when deciding to which prison to send an older prisoner. He told us:

> [...] age and infirmity are certainly considered in deciding whether or not a prisoner is in the right prison. Most of our prisons will have the capacity to accommodate people with mobility problems, but [...] some of the older prisons are more challenging than some of the newer ones. That is part of the reason and logic behind a strategy on estates that transfers us from an older Victorian estate, in many cases, towards a much more modern estate, where we can design in some features that will allow this to be managed better.[58]

Dr Stuart Ware, however, said that one of the outcomes of his research was that:

> [...] where specific assessed care needs of older people with disabilities are assessed, their care plans may require them to receive specific services that their current prison placement cannot meet. You cannot expect a prison like Dartmoor, with very small entrances to their cells, to be able to provide wheelchair access throughout the prison. We found similar problems in the main Albany block in HMP Isle of Wight.[59]

40. ***Many older prisoners are currently being held in establishments that cannot meet their needs. We are not confident that older prisoners are assessed before their entry into prison and, if they are, whether this has any impact on allocation.*** **We accept that for operational and practical reasons it will not always be possible to allocate older prisoners to entirely suitable prisons, but NOMS should, as a rule, not allocate such a prisoner to an establishment that cannot meet their needs.**

Age specific regime

41. HMIP found in their 2008 investigation, and subsequently in their 2012 annual report, that although older prisoners were often unlocked during the day, there was often very little age specific or appropriate activity. Day centres are not typical.[60] Prisoners can choose to continue working past the usual retirement age, which is the same as in the community, but they are not compelled to do so. We met prisoners who were over 65 and still worked. These tended to be prisoners who had recently entered the prison system for the first time. Others who did not work, and so used the age specific activities, had needs that prevented them from participating in the prison regime:

> With the education department located on two floors with no lift it is not possible for some to take part in some classes.

57 Q 130

58 Q 120

59 Q 101

60 Ev 41

> One barrier at this prison to access learning in the education department is the amount of steep stairs that have to be climbed; for some senior people this is impossible.[61]

42. Various regimes have been developed throughout the prison estate to cater specifically for older prisoners. Frequently cited as good examples are age specific activities and day centres which prisoners can attend after they stop working. Good examples include the day centre that we saw at HMP Isle of Wight and the Diversity Centre run by RECOOP at HMP Dartmoor. Prisoners reported to us that both centres provided fulfilling occupation of their time and where possible prepared them for resettlement. At HMP Dartmoor we saw older prisoners socialising in the day centre as well as working on a broad range of craft projects. The centre also provided work for those who wanted to stay in their cells. Older prisoners were highly engaged with the Diversity centre, and staff estimated that only a small proportion refused to engage with the centre. At HMP Isle of Wight there is a specific older prisoners regime and policy, by which older prisoners are treated distinctively and with understanding. Key elements of the regime are:

- Monthly older prisoner forums, supported by RECOOP
- Wing buddies and pad pals are appointed to support older prisoners
- Education and work for those who are able to do so
- Employment on the wing (including tea packing and rug making)
- An over 50s gym session
- On wing library
- On wing education in art, literacy and numeracy
- Pastoral care
- Disability helpers (see paragraph 76)

43. Older prisoner forums have been cited to us in evidence as particularly important in managing an older prisoner population and can be an effective way to provide feedback on the success of a regime as well as equality management. RECOOP recommended that all prisons should have an older prisoner forum. NOMS awarded a grant from 2012–14 to RECOOP to build on their work in the South West by improving the capacity of prisons, probation trusts and voluntary sector organisations across England and Wales in working with older offenders. Consultants from RECOOP have developed programmes within prisons to directly provide activities or to provide education towards them. As part of this project RECOOP has developed their website to include a members' area that provides a range of resources for professionals working with older offenders.

44. The Prisoners Education Trust, however, reported that broadly there existed no age appropriate education programmes; the focus of the programmes on employability was

61 Ev w34 [Prisoners Education Trust]

said, in their surveys, to be of minimal use for older prisoners.[62] The aims of education for older prisoners may be different than younger prisoners:

> Older prisoners are often looking for recreational learning to keep their mind stimulated, not to enhance their chance of employment when released.[63]

45. ***We welcome the work of RECOOP, commissioned by NOMS to provide services within prisons to promote the wellbeing of older prisoners. We were impressed by the diversity centre which they ran with prison officers at HMP Dartmoor and the calm, constructive atmosphere that it created. We recommend the expansion of such projects more fully into other prisons.***

46. **When older prisoners are unable to work, or to engage with the normal prison regime it is important that they have a regime that allows them to be as active and productive as possible. We recommend that NOMS should ensure all prisons have an older prisoner policy that provides age specific regimes for older prisoners.**

The integration or segregation of older prisoners

47. When older prisoners reach a stage where they are frail and vulnerable and no longer able to fully partake in the normal prison regime, some prisons have chosen to create older prisoner units. The aim is to provide more effective care for those who share severe health and social care needs. A notable example of this is the Elderly Lifers unit at HMP Norwich.[64] Opinion among those who gave evidence to us is divided as to whether older prisoner should be held in separate units.

48. One of the arguments in favour of segregation is that specific units could allow for a concentration of specialised staff and resources for the elderly which reduces cost.[65] Such units can also be designed to provide a suitable physical environment. Older prisoners, also, frequently feel unsafe in the broader prison environment; HMIP reported two out of five older prisoners had felt unsafe and 15% had been victimised. As we note in other areas of this Report, older prisoners are particularly vulnerable to victimisation.[66]

49. The majority of opinions expressed to us, however, suggest that full segregation is generally neither the wish of older prisoners nor an effective way to manage them. The IMB Norwich summarised the dangers of segregation in their report on the elderly lifers wing:

> It has the `feel' of a rather sad old people's home with fewer visitors and little to do. The rather cheerless large sitting room with a games table and big TV is often nearly empty. E Wing is to be re-roled as a quieter, `mature unit' following the re-role in

62 Ev w34

63 *Ibid.*

64 Ev w28 [Dr Elaine Crawley]

65 Ev 38

66 Ev 41; and see below, para 73.

> March 2012, aiming to provide prisoners with a peaceful environment away from the hubbub of the other wings".[67]

50. The provision of separate areas specifically for older prisoners is supported by academics and by HMIP.[68] Older prisoners consistently reported to us that they wanted to be mixed with the rest of the prisoner population and did not want to be isolated. It is worth noting that both of the populations we met were vulnerable prisoners and so were protected to an extent by the separate vulnerable prisoner regime. Integration may not be such an attractive prospect in a regime that is not already isolated.

51. The Minister and Mr Spurr also both reported to us the benefit that they saw for the management of the prison population as a result of the calming influence older prisoners had on the younger prisoners.

> If we were to be institutional about it, from our point of view, in the management of the prison system, it is quite a good thing to have a mix of ages, because what you can find is that older prisoners have a positive and calming influence on younger prisoners. It may be very much in our interests to see a mix of ages [...] From our perspective there are huge advantages in having a mix, but in the end we want to accommodate the needs of each individual prisoner, whatever they may be.[69]

52. ***The integration of prisoners of different ages in prisons has potential benefits for all elements of the prison population and management. In general, we do not see that there is a need for the expansion of segregated older prisoner units or wings. This, however, places greater emphasis on the need within the general prison environment to establish day centres and regimes that provide for the needs of older prisoners.***

67 Ev 60 [Association of Members of Independent Monitoring Boards]

68 Q 38 [Dr Wahidin]

69 Qq 120–1 [Jeremy Wright MP]

3 Health and social care of older prisoners

53. Under Prison Service Order 3050 prisoners are entitled to an equivalent level of healthcare in prison equivalent to that which they could have expected to receive in the community.[70] As set out in Chapter 1 older prisoners' physical and mental health is characterised by high levels of chronic illness and mental disorders. In terms of social care they often have extensive needs driven by high levels of disability. This Chapter explores the extent to which needs are currently met.

The healthcare of older prisoners

Changes to provision

54. On 1 April 2013 the NHS Commissioning Board assumed responsibility for all health services, including substance misuse services, for people in prison in England. Prisoners in Wales will remain under the responsibility of Local Health Boards in three prisons while the Ministry of Justice directly commissions primary healthcare at a single contracted prison. Bruce Calderwood, from the Department of Health, explained how the new commissioning arrangements would work in prisons.

> Before April, commissioning was through PCTs—primary care trusts—which are independent of each other. Now, NHS England, as a national organisation, is responsible, but something like its 10 area teams will take responsibility for particular bits of the country and they will work to consistent standards [...] There are 27 local area teams. NHS England has asked 10 of them across the country to say, for a larger group, that they will commission all prison health care.[71]

Problems in provision

55. The drive to enhance consistency of provision across these ten larger regions is welcome in the context of variability in the standard of healthcare that is provided to older prisoners under the previous system. In 2008 HM Inspectorate of Prisons found some variability in the provision of services. The key criticism was a lack of focus on the health of older prisoners. For example, the National Service Framework for Older People requires that there should be a lead nurse for older prisoners, but only 11 of the surveyed prisons reported that their healthcare services had a lead nurse for or a focus on older prisoners.[72] Sean Humber from Leigh Day, a law firm that specialises in the treatment of older prisoners emphasised the variability of prison healthcare in evidence to us.

70 Prisons and Probation Ombudsman, *Learning from investigations: end of life care,* March 2013

71 Q 140 and Q 142

72 HM Chief Inspector of Prisons, *Older prisoners in England and Wales: a follow up to the 2004 thematic review,* June 2008, p.29

> The problem was that it was transferred to the primary care trusts dotted up and down the country, which were responsible for the prisons in their area. It is fair to say that some did a good job but some did a less good job.[73]

56. Leigh Day highlighted the following issues of concern relating to healthcare of older prisoners:

- The failure to adequately assess their health problems upon their arrival at prison;
- The failure to contact their community GP and to obtain copies of their medical records to confirm their health problems and medications;
- Significant delays and practical difficulties in them seeing a nurse or a GP;
- A reluctance to prescribe them certain pain relief medications even if they were prescribed them before imprisonment, and a reluctance to prescribe them certain pain relief medications in possession or to dispense at certain times (which means that the medications are not taken at the correct times);
- A reluctance to refer them to hospital for investigation or treatment even if they were under the care of a consultant before imprisonment;
- Delays in attending the hospital appointment either because it has been cancelled or missed (which means that average waiting times are much longer than those in the community);
- Handcuffing during consultations or tests and examinations despite suffering chronic health problems or disabilities (which means they are denied dignity and privacy during treatment); and
- Transfers to other prison whilst waiting to be seen by or under the care of a consultant (which means they are often put back to the bottom of the waiting list or their treatment is disrupted).[74]

A number of prisoners described their experiences to us:

> One of my fellow inmates [...] was diagnosed with prostate cancer last July but has received no definitive treatment yet. "Healthcare", here—as in most British prisons—is an "oxymoron."[75]

> Medical care "in prison" is only ever obtained by extensive lobbying form filling and extensive advocacy. Elderly prisoners often give up and fall through the cracks. [76]

> My doctor has prescribed me medication for "dangerously high blood pressure" His words, not mine. 29 of January I went for repeat prescription. Nurse snapped at me

73 Q 47

74 Ev 68

75 Ev w1 [Prisoner A]

76 Ev w1 [Prisoner B]

> "Your medication cancelled 19 January!" Many of us older folk here take daily aspirin 25mg. However we are frequently told, "Out of stock!"[77]

57. Leigh Day attributed these problems to a number of contributory factors :

> First, with regard to older prisoners in particular, not all Healthcare Departments have specialist healthcare services for older prisoners. Older prisoners have very different health care needs in their nature and extent from younger prisoners ... more time needs to be spent contacting their community GP and obtaining their medical records to confirm their health problems and medications, they need more regular appointments with a nurse or GP or they need more regular hospital appointments[78]

58. A prisoner's wife described the effect of repeated cancellation of hospital appointments for her husband:

> The delay was apparently the result of hospital appointments having been cancelled by Prison Security, and then not re-booked. By the time the operation was carried out, the affected area had increased so much that a skin graft was necessary, needing 19 stitches instead of the original estimate of 2, and his face is now permanently disfigured.[79]

59. ***We recognise that some of the difficulties in accessing healthcare experienced by older prisoners mirror the experiences of healthcare of many in the community. Older prisoners, however, do experience particular barriers to accessing healthcare services.*** **For example, cancelled hospital appointments because of a lack of communication between healthcare and prison officers are entirely avoidable and NOMS should take steps to ensure greater coordination between the two. All prisons should follow the Department of Health guidelines as set out in the National Service Framework for Older People that they should have an nurse lead for older prisoners who can develop a specialty in the provision and dedicate time towards the extra practical demands of that older prisoners present as patients.**

Mental healthcare provision

60. Mental healthcare needs are widespread in the prison population but, as HMIP recognised in their 2008 report, levels of depression are elevated in the older prisoner population.[80] In their 2004 report they asserted that the mental health needs of older prisoners go unrecognised and thus untreated; this is partly because of a confusion between the effects of old age and treatable symptoms of mental health disorders by older prisoners, professionals themselves as well as prison staff.[81] A lack of training to allow staff to recognise specific health problems specifically in older prisoners was identified by HMIP

77 Ev w2 [Prisoner C]

78 Ev 68

79 Ev w42

80 HM Chief Inspector of Prisons, *Older prisoners in England and Wales: a follow up to the 2004 thematic review,* June 2008, p.29

81 HM Inspectorate of Prisons, *'No problems: Old and Quiet': Older prisoners in England and Wales,* September 2004, para 3.23

in their 2008 report as a significant problem.[82] Some steps have been taken to correct this; NOMS commissioned services by RECOOP have begun to run courses for both staff and older prisoners themselves.[83] Others such as Age UK and the Alzheimer's Society run specific dementia services in prisons with large populations of older prisoners, for example HMP Dartmoor and Exeter.[84] On our visit to HMP Isle of Wight we were told that they encouraged staff to undertake mental health awareness training and that officers were supported in the attainment of a relevant National Relevant Qualification.

61. Despite this good practice, unmet needs remain. The Offender Health Research Network found in their study that 34% of older prisoners they surveyed registered to be psychologically distressed adequate treatment to counter it. Professor Shaw also reported to us that the Network's research suggested that few received treatment for their depression.

> What was striking with that was that only one in five of the people who had depression were on antidepressants and only one in six were in contact with the services.[85]

62. Problems in communication between agencies and organisations that work with older prisoners have also been reported with regard to the provision of mental healthcare, The British Psychological Society raised concerns that need was not being met for older prisoners, and suggested there were four causes of inefficacy in mental healthcare:

- The high demand on prison in-reach teams, few of which contain practitioner psychologist as an integral member.
- The absence of older adult specialists within those teams.
- That these teams are normally based outside the prison estate; the generally poor liaison between prison psychologists and in-reach psychologists, with some notable exceptions.
- The significant cultural differences between the prison service and the NHS which leads to frequent misunderstanding and poor or non-existent liaison.[86]

63. ***The unmet mental healthcare needs of older prisoners are extensive. The way to combat this is to raise awareness and enhance training among all those in the prison community – to recognise where mental health problems exist and to refer appropriately.*** **We commend the organisations that provide awareness training inside prisons and we urge NOMS to encourage officers to obtain relevant training and consider integrating it into standard prison officer training.**

82 HM Chief Inspector of Prisons, *Older prisoners in England and Wales: a follow up to the 2004 thematic review,* June 2008, p.10

83 Ev 55

84 Ev w26 [Centre for Mental Health and the Mental Health Foundation]

85 Q 74

86 Ev w17

"Clinical hold"

64. "Clinical hold" is the mechanism by which clinicians request that prisoners are not moved from their current prison on health grounds.[87] Older prisoners who are moved around the prison estate reportedly experience worse health outcomes as a result. We met a prisoner at HMP Isle of Wight who had previously been held in a local prison; a short period of time before he was moved to the Isle of Wight he had told us he been due to undergo an invasive operation for a chronic illness. This operation had been unable to take place as a result of his move and over six months later the operation had still to take place. This experience was far from unique from evidence that we have received. Professor Shaw commented on her own experiences of treating prisoners:

> We do try to hold people. If we are treating them we can put on a medical hold, as it is called. That is quite often effective at getting the prison to keep somebody who is going through treatment—but not always so. It is a definite area that we need to work on because it causes enormous problems for prisoners. Particularly if they are quite troublesome prisoners, they tend to get moved all the time, which is probably the worst thing that could happen, because in a way you want them to have some stability, so you can get to the problem. We are constantly, on a local level, trying to work with our own prisons on this, to get them to keep hold of people, particularly if they are going through a period of treatment. Anecdotally, we are getting there a bit, but it needs much further attention.[88]

65. **In a situation in which clinicians believes that medical treatment warrants a clinical hold of a prisoner, it should not be a challenge for them to obtain it. As long as there are no overriding security concerns then effective provision of healthcare should guide NOMS in the timings of moving ill prisoners.**

IT connections and continuity of care

66. A criticism which we have heard regularly through the course of our visits and evidence sessions was about the continuity of care between prisons, and between the secure estate and the community. For example, the computer system used by the NHS in the community does not connect to that used by healthcare teams in prison. This presents obvious difficulties in transferring details of existing physical and mental health needs that exist on entry into prison, and has significant needs. This issue was raised as a common problem to us at both HMP Dartmoor and Isle of Wight. Dr Brew commented on his frustrations in receiving very little about the prisoners at HMP Leeds.

> We are doing our best to achieve [joined-up healthcare], but when we ask for information from local GPs, because the two computer spines are not linked, we

87 National Offender Management Service, *Prison Service Order 3050*, Issue no. 254, February 2006

88 Q 81

> often get a single sheet of paper, which is the whole medical record, even for someone who has complex needs. [89]

67. We asked Bruce Calderwood, Director of Mental Health, Disability and Equality at the Department of Health, about the absence of the connection between the respective IT systems. He acknowledged the problem, but stopped short of giving assurances that it would be resolved.

> One of the challenges, certainly as far as the NHS is concerned, is that the prison healthcare systems are not connected into what is described as the national spine, which enables easy transfer of information. One of the things that NHS England is looking at is the time scale and cost of moving into ensuring that link is made. I cannot give you a commitment now as to when that is going to be because it depends on the money becoming available, but they are hoping that by 2016 that kind of link is effective, which would mean that there ought to be the same sort of connectivity between the NHS healthcare systems and healthcare systems outside prisons that exist across the country.[90]

68. This explanation seems to locate the root of the problem as the cost and scale of connecting such a system. This differs from the explanations given to us by senior management on our visits to HMP Dartmoor and Isle of Wight, and Dr Brew, who attributed the failure to connect the IT systems to NOMS security concerns:

> The Secure Environments Group at the RCGP often discusses this and the push towards getting the NHS IT systems to merge. The resistance is from NOMS, primarily because of security and some very high-profile people. We wouldn't want to know where they are.[91]

69. We asked the Minister about connection of computer systems to allow for effective transfer of information. He supported such a system in relation to different forms of treatment:

> Part of the advantage of not just this better link-up in the transfer of information, but, frankly, also better linking of the work done on rehabilitation more generally in prison and through the gate out into the community is to be able to start a drug treatment programme even though you know it will not be completed when someone is in prison because you will be confident that you can carry it on outside. [The Ministry of Justice and The Department of Health] are working closely together on providing this to make sure that we can start that process [...] This kind of linking will have very practical advantages to some of the most significant problems we are dealing with.[92]

89 Q 79

90 Q 144 [Mr Calderwood]

91 Q 80 [Dr Brew]

92 Q 144 [Mr Wright}

70. ***The failure to connect the community healthcare and prison IT systems has a tangible and negative impact on the healthcare outcomes of older offenders when they enter prison, and when they leave prison it disrupts continuity of care. It frustrates prison healthcare teams and exacerbates the pressures placed on them.*** **We share the Minister's enthusiasm for the more effective transfer of information between those who provide services for offenders during their sentence and after they leave prison. This would be of particular benefit to the treatment of older prisoners with chronic and complex health needs. The NHS Commissioning Board and NOMS should work together to connect the prison healthcare IT systems with the NHS in the community, taking into account security concerns. We intend to monitor progress on this matter.**

The social care of older prisoners

71. The social care needs of older prisoners that arise from old age and the particularly high incidence of disability are significant. We have received extensive and striking evidence that has suggested to us that current provision is sparse, variable and in some cases "non-existent".[93] Most poignant was the dearth of social care that was provided to two older prisoners at HMP Winchester, referred to in paragraph 29 above.

72. Some of the causes of these problems were structural, but there were also cases where prison staff are unaware of social care needs. Reliance on other prisoners for help is indicative of an absence in provision and responsibility for social care of older prisoners. Research conducted by the Offender Health Research Network reflects the idea that social care in some cases has simply not been provided for by any agency or institution:

> One interviewee described how prison staff often considered the social care of older prisoners to be the responsibility of other prisoners rather than staff and therefore other prisoners would often be left to assist older prisoners with their social care needs without adequate training to undertake such tasks.[94]

Professor Shaw told us that social care was the biggest problem in provision:

> The most striking finding was that staff reported that there was a virtual non-existent provision of social care and that was the main and significant problem, because, while most people had older prisoner leads, there was a problem with health and social care policy that only about half of the prisons had one, and they said the particular problem there was the social care bit of that.[95]

73. Nick Hardwick, HM Chief Inspector of Prisons, told us of the risks of leaving old and frail prisoners to arrange their own social care:

> The other day, I was in a prison where no care was provided for a prisoner with severe mobility problems. As a consequence, he was having to make his own arrangements to get other prisoners to fetch his meals for him. He was then being

93 Ev 68; see also Q 51 [Helen Boothman]

94 Ev 49

95 Q 74

> bullied and intimidated by the people he was asking those favours of. There was no formal social care for him, so that ad hoc arrangement was placing him at risk.[96]

74. Sometimes social care has been provided by charitable organisations or by prison officers who will resolve the situation on their own initiative. We met some excellent prison officers who had developed a close relationship with older prisoners and provided clearly effective care and support with the resources that they had; these were often the older prisoner leads or the disability liaison officer. Older prisoners in their submissions to us frequently praised such individuals:

> On a positive note, [HMP] Bullingdon's Edgcutt wing had an officer designated as having responsibility for older and disabled prisoners, and he discharged that responsibility very well, sometimes in the face of internal opposition.[97]

75. Formal responsibility for the provision of social care of older prisoners has been unclear. While prisons have a broad duty of care to provide adequate provision for daily living they do not have specific responsibility to provide or commission social care. In practice we have found that it was often the case that no one was sure who was responsible. Staff told us that responsibility to assess and provide for the needs of individuals usually lay with the local authority where the older prisoner was previously resident.[98] This presented practical problems from a prison's perspective as older prisoners are often several hundred miles away their home local authority. Leigh Day reported to us in their experience this distance resulted in local authorities simply not fulfilling their responsibilities:

> Local Authorities do not have any involvement with older prisoners. Prior to their imprisonment, our clients are often assessed for and provided with social care in their homes by Local Authorities. However, upon their imprisonment, our clients have had little or no contact with Local Authorities.[99]

Care provided by other prisoners

76. On our visits to HMP Isle of Wight and HMP Dartmoor we saw some of the care work that was carried out on an informal basis by other prisoners for older prisoners who required help. 'Buddy' systems pair a younger or more able prisoner – who has often been convicted for a similar offence – conduct a variety of social care activities for older prisoners. At HMP Isle of Wight prisoners can work as disability helpers; staff prisoners received training to achieve a Diploma in Health and Social Care from The Isle of Wight College to prepare them for the role. The job description involves the following tasks:

- Collect meals;
- Collect newspapers and magazines;

96 Q 28

97 Ev w58 [Prisoner O]

98 This follows local authorities' responsibility to provide social care for those who are 'ordinarily resident' as established in the National Health Service and Community Care Act 1990

99 Ev 68

- Make bed;
- Clean cell;
- Deposit and collect laundry; and
- Inform wing staff or disability liaison officer if there are any areas of concern such as deterioration of disability

These are all tasks which prisoners are required to carry out by themselves, but which disabled older prisoners may be physically incapable of carrying out.

77. At HMP Dartmoor staff told us about the importance and success of the buddy system for both young and old prisoners; they are also given dementia training to aid in the identification of mental deterioration. Personal and intimate care cannot be undertaken because of the risks of abuse associated and so the scope of the social care that can be provided is limited. This kind of work may contribute to the "calming" effect that the Minister claimed older prisoners have on the younger cohorts; our experience from meeting those who worked and benefited from the system reflected this. It is a practice that was advocated by Age UK in their guide to supporting older prisoners and by HMIP.[100]

Developments in the Care Bill

78. The Law Commission, as part of their review of Adult Social Care, considered the care of prisoners. It came to the conclusion that statutory responsibility for the social care of prisoners did lie with the local authority in which they were ordinarily resident, but there were a number of barriers to achieving successful care, including, in Leigh Day's summary:

- The assumption that the Prison and the Healthcare Department are already providing social care services to prisoners; and
- A lack of clarity as to which Local Authority would be responsible for the assessment and provision of social care under the "ordinary residence" criteria; and
- A lack of clarity as to whether or not the eligibility criteria can be applied to a prison context, and, if so, whether or not it would unfairly discriminate against prisoners (i.e. would a prisoner be eligible for social care before imprisonment but not during imprisonment).[101]

Following the Law Commission report, the Government brought forward the Care Bill which is currently making its way through Parliament. Clause 69 (1) and (2) of the Bill make clear that the local authority in whose area a prison is located will be responsible for providing assessments and meeting care and support needs for the residents of those custodial settings.[102] A prisoner's previous ordinary residence will not be a consideration while they are in these settings, and responsibility will fall to the local authority area in

100 Age UK, *Supporting older people in prison: ideas for practice,* June 2011, www.ageuk.org.uk/professional-resources

101 Ev 68

102 Care Bill [*Lords*], clause 69,[Bill 1 (2013–14)]

whose area the prison or approved premises is located without reference to the general ordinary residence criteria. The Impact Assessment to the Bill estimates that the total cost of assessment and provision of social care in prisons will be £8.6 million, of which £6.4 million will be required for prisoners over the age of 50. Of this cost, £2.7 million is allocated for assessment of older prisoners and £3.7 million for the provision of social care.[103]

79. **The lack of provision for essential social care for older prisoners, the confusion about who should be providing it, and the failure of so many authorities to accept responsibility for it, have been disgraceful. We welcome the fact that clarity of responsibility is provided in section 69 of the Care Bill. Prisoners, like all those who are resident in the local authority in which a prison situated, will qualify for the provision of social care should an assessment of their needs meet eligibility criteria which will be established by regulation under clause 13(6) of the Bill. Clarification is needed as to how local authorities with large prison populations will be assisted with the funding which will be required for them to provide social care.**

80. **The Secretary of State for Health must now work with NOMS and the Minister for Prisons and Rehabilitation to develop criteria which effectively resolve the Law Commission's concern that local authorities do not understand the level of care that prisons provide and the specific needs of prisoners.**

81. There are, however, further issues of concern that may not be resolved by clarifying statutory responsibility for the social care of prisoners. The Care Bill will do nothing in itself to resolve the practical problems of communication that exist between agencies and institutions. The Royal College of Psychiatrists highlighted this:

> The social care of older prisoners is problematic, however, as prison health staff will have very little knowledge or experience of liaising with community old age services. An older prisoner lead for each prison is one such solution to this, and many prisons have adopted this strategy. If a national strategy is adopted then delineating the possible roles of such a lead will be a dramatic improvement on the current ad hoc arrangements that exist in each prison.[104]

82. Nick Hardwick also raised a concern that:

> If, for instance, the principal local authority is responsible for social care, the danger is that the prisons will no longer feel responsible for that, so their responsibility will be taken away [...] There are risks, in terms of social care, of older prisoners slipping through the gap.[105]

83. **Clarifying statutory responsibility for social care is a welcome step in improving the provision of social care for older prisoners. It is not, however, a sufficient guarantee for**

103 Department of Health, *Impact Assessment, Care and Support Legal Reform (Part 1 of the Care Bill [Lords] [Bill 1*, (2013–14)]) , Table 17

104 Ev 65

105 Q 15

effective outcomes. We consider that NOMS should prepare guidance for prisons in liaising with local authorities social care teams, and should issue a Prison Service Instruction specifying the extent to which it expects officers to carry out basic social care.

84. ***Some local authorities will face considerable pressure on resources in meeting their new responsibility in the provision of care for older prisoners. While the provision of funding for the service is welcome, there is potential for disparity in the service provided by different local authorities.*** **We recommend that NOMS should set out the minimum standards of care it expects for older prisoners with severe social care needs. It should also guide prisons in their coordination with local authorities. NOMS should consider placing social workers in prisons to work with older prisoners and others with social care needs, as in the effective model that we saw at HMP Isle of Wight.**

Assessment of needs on entry and during a sentence

85. The efficacy of assessment of prisoner's health, mental health and social care needs by prisons has been questioned by evidence we have received. Sean Humber told us that assessment on entry into a prison is fragmented:

> There seems to me to be a lack of rigorous assessment of disability needs when the prisoner gets to prison. On reception, there is a questionnaire they can fill in that talks in one-word terms about whether they have disabilities. There is often a health care assessment a few days later that looks at health care issues, hopefully in more detail. However, often there does not seem to be joined-up thinking about how it will impact on what you can and cannot do if you have reduced mobility. Will you be able to get to the library or to visits? Will you be able to use the gym? Will you be doing this, that or the other? There does not seem to be follow-through from the initial one-word assessment and the health care assessment about how that impacts on a day-today basis.[106]

Dr Stuart Ware reported this experience working with assessment at HMP Isle of Wight to us:

> When we commenced the evaluation, we found out that in the relatively local, small Isle of Wight Council there were over 100 separate assessments of needs carried out by different agencies. This led to a duplication of assessments. If someone had multiple care needs, the prison would call in a professional from a caring agency to carry out that assessment. There was a multiplication of care assessments with the agencies repeating similar care questions to the same older prisoner. We found there was marked failure of inter-agency communication and unwillingness to share information.[107]

106 Q 59 [Sean Humber]

107 Q 101

This is mirrored in HMIP's recent report into HMP Lindholme, where it found that there was no coordinated system to assess the needs of older prisoners or those with disabilities.[108]

86. This was not a sentiment that was shared by Michael Spurr, Chief Executive of NOMS. He said in evidence to us that:

> Our standards require individual assessment of need and appropriate provision for that need. That includes people with needs who are older in prison. In the work we have been doing with our health partners, and now through NHS England, there is a clear and improved screening for prisoners coming through in health needs, which is a particular issue for older prisoners.[109]

The Offender Health Research Network, however, told us that the Department of Health recommendation that there should be a specific assessment of health and social care needs on entry for older people was largely unmet suggesting the minimum standards to which Mr Spurr referred may be ignored.[110]

87. For long sentenced prisoners who age in prison, continual assessment of need may be of equal significance to initial assessment. Some establishments have effective mechanisms to do this for older prisoners. "The Lobster Pot", a day care centre run by RECOOP for the over 50s population at HMP Leyhill, was judged to be an excellent resource by HMIP; the training and activities that took place allowed staff to conduct dynamic assessment.[111] The deterioration of health with age requires this kind of regular assessment. Dr Ware told us that at HMP Isle of Wight, prisoners over the age of 50 were given care assessments every six months; this, again, follows the Department of Health's 2007 guidelines. [112]

Common Assessment Framework and the Older Prisoner Health Care Assessment Plan

88. Two particular examples of effective assessment on entry have been brought to our attention. They both allow for comprehensive assessment and referral, subsequent review and to eventually pass on to community services on release or to another prison. The aim of the Common Assessment Framework pilot (CAF), at HMP Isle of Wight was to develop an integrated assessment of health, mental health and social care needs on initial arrival to remedy the lack of information that the prison authorities receive and to develop a system of continual referral and provision so that "funding might follow the individual with assessed care needs".[113] This included the carrying out of care assessments, referrals to other agencies, provision of social care equipment and the running of twice weekly social care "surgeries".[114] This is done partly to provide for appropriate services in the prison, but

108 HM Chief Inspector of Prisons, *Report on an unannounced inspection of HMP Lindholme*, June 2013

109 Q 118 {Michael Spurr]

110 Ev 49

111 Ev 41

112 Q 101

113 Q 103

114 Ev 66

also to develop a Health and Social Care Passport. Dr Ware, who conducted research into the CAF pilot, concluded that it provided cost-effective interventions, and that it resulted in the continuance of care in the community and a subsequent reduction in recall as a result of breach of licence.[115] HMIP and Prison Reform Trust both noted the success of the project, and the Minister in evidence to us supported the model piloted on HMP Isle of Wight:

> There should be one assessment that is done, and, if it is done in prison, it moves with the individual because of the need to move with the individual when they are going back into the community; so, yes.[116]

Similarly, the Offender Health Research Network has developed a single form which provides for holistic assessment of needs within 10 days of entry into a prison. The Older Prisoner Health Care Assessment Plan, conducted by the Older Prisoner Lead, is divided into three areas: wellbeing, social care and discharge from prison. It revisits information that may already have been provided on initial reception, and identifies new information that has come to light following a few days in custody. It then explores any issues relevant to release and life in the community.

89. ***Whatever precise model is adopted, assessment of health and social care needs on entry into prison and subsequent review that follows prisoners through their sentence up to and including release rationalises resources and is an effective way of unifying the complex needs of older prisoners*. Such assessments should be provided for all prisoners who enter prison at an advanced age, and who age whilst in prison.**

End of life care

90. With increasing numbers of older people in prison, there will inevitably be an increase in the number of prisoners who die in custody. Unsurprisingly the majority of prisoners who died natural deaths in custody between 2007 and 2010 were over the age of 55.[117] End of life care is facilitated by prisons in instances of foreseeable death following terminal illness, and is provided for at the same standard of care as in the community. Prisoners have a choice about where they die. Between 2007 and 2012 the majority of prisoners who died of natural causes did so in hospital (54%), more than a quarter died in prison (30%) and 15% died in a hospice. The majority of prisoners who died in prison were in the healthcare centre (73%) and 17 prisoners died in their cell. The PPO found that this broadly reflected what happens in the community for patients with cancer.[118]

How well is palliative care provided?

91. We have received evidence that suggests to us that palliative care is broadly well provided in prisons. We have heard about several examples of palliative care suites which

115 Ev 66

116 Q 153

117 Prisons and Probation Ombudsman, *Learning from PPO Investigations: Natural cause deaths in custody 2007–2010*, March 2012, para 1.2.

118 Prisons and Probation Ombudsman, *Learning from PPO Investigations: End of Life Care*, March 2013, para 3.5

provide for effective care. Prisoners frequently choose to die in their cells; this was reported as having been well managed by one older prisoner who submitted evidence to us about the death of a fellow prisoner:

> The recent death of a terminally ill patient allowed me to observe the palliative care given by medical and wing staff [at HMP Parc]. Everything that could be done, was done, with doctor and nursing staff constantly in attendance. Every courtesy was extended to the family including 24 hour access to this person's bedside, with wing staff, led by the unit manager taking it in turns to remain on the wing overnight to support the family and allow 24 hour access to the inmate.[119]

Equally HMIP reported to us that broadly end of life care was exercised with compassion:

> Our experience is that, if you have a situation where someone is in end–of–life care, governors will often meet family and relatives as part of that process, for genuinely humane reasons.[120]

Other examples of good practice included the use of hospices:

> [...] in the north-east prison cluster, the Prison Service, the NHS and the Macmillan cancer charity have to date trained some 90 health care and prison staff in palliative care, which is a pretty specialist area of care. That means that there are now some good examples—champions, if you like—of the sorts of care needs that will be required going forward being addressed by training.[121]

Use of restraint during end of life care

92. The Prisons and Probations Ombudsman considered 170 cases of natural deaths of prisoners in his investigation into end of life care; in 32 cases he found inappropriate use restraint in hospital or a hospice; in at least 21 he found this to be the case during treatment; in 18 cases there was inappropriate restraint a prisoner was under escort to a hospital or hospice. His report gives two alarming examples of excessive use of restraint, one in which a prisoner was restrained whilst in a coma, and another in which a prisoner died which handcuffed to the escorting prison officer.[122] Clinicians may not have the ability to influence the decisions of prison officers with regard to restraint. The BMA offers this advice to its members:

> Health professionals are often unsure as to whether they are entitled to ask for handcuffs to be removed during assessment and treatment and whether they can ask accompanying guards to leave the room. They should certainly do so if the method of restraint interferes with treatment or if the detained person is clearly too

119 Ev w7 [Prisoner J]

120 Q 26

121 Q 13 [Nigel Newcomen]

122 Prisons and Probation Ombudsman, *Learning from PPO Investigations: End of Life Care*, March 2013, para 3.6.2

> incapacitated either to threaten others or to abscond. The general advice given to prison staff around the UK is to comply where feasible with such requests.[123]

Peter McParlin, from the Prison Officers' Association, told us that prison officers are in a very difficult position in this situation:

> If ever someone escapes, it will have to answer questions from Chris Grayling or Jeremy Wright at the Ministry of Justice, who do not want to see any escapes on their watch and the attendant publicity that goes with that, depending on the type of offence the prisoner has committed. Hence, prison officers have no discretion whatsoever to remove restraints at a hospital bed [...] It is an awful situation for my members, but that decision is taken out of their hands.[124]

93. The NHS National End of Life Programme cites a Marie Curie hospice that works with the Durham prison cluster to provide palliative care; the hospice insisted that prisoners are not handcuffed at the hospice and that prison officers are not uniformed. Local guidelines were developed to allow the provision of hospice services for high risk offenders.[125] There is, however, a continuous tension with security. Terminal illness does not necessarily mean that a prisoner cannot escape or will not commit an offence in a hospital. The Minister outlined this to us:

> One of the key points of vulnerability for us is the period of transfer from a prison to a hospital. The public would expect us to take the necessary precautions to ensure that prisoners cannot get away from that environment or cause any harm while they are in it. Some form of restraint is sadly necessary.[126]

94. **The Prisons and Probation Ombudsman noted in his report into end of life care that NOMS were undertaking work into developing new guidelines in the use of restraint in clinical environments. This provides an opportune moment to assess whether the balance between security and compassion is sufficiently achieved. It is right that prison management should give guidance about the removal of restraint in cases of terminal illness and we recognise the pressure that prison officers would be under to remove a prisoner's restraints, potentially at the expense of security. The pendulum seems to have swung too far by excluding the exercise of judgement by experienced prison officers in these situations.**

Release on compassionate grounds or to home detention

95. The possibility for release on temporary licence on compassionate grounds is an element of care planning for a prisoner with a terminal illness.[127] Prison Service Order 6000

123 British Medical Association, *Guidance from the British Medical Association, The medical role in restraint and control: custodial settings,*2009, available to download from www.bma.org.uk

124 Qq 21–22

125 NHS National End of Life Care Programme, 2011, *The route to success in end of life care – achieving quality in prisons and for prisoners*, 2011, p.21

126 Q 129

127 Q 91 [Dr Brew]

governs such release for prisoners serving determinate sentences, and Prison Service Order 4700 for those serving indeterminate sentences. Both PSOs guide governors to consider release on the following grounds; the prisoner is suffering from a terminal illness and death is likely to occur within three months; the prisoner is bedridden or similarly incapacitated; the risk of re-offending is past; there are adequate arrangements for the prisoner's care and treatment outside prison; early release will bring some significant benefit to the prisoner or his/her family.[128] The criteria are largely the same for indeterminate and determinate sentence prisoners. Another type of release that may be considered is release to Home Detention Curfew (HDC), but this is limited to those serving sentences between 12 months and four years, and sex offenders and foreign nationals are statutorily prohibited from HDC.[129]

96. The use of release on compassionate grounds must be approved by the Minister for Prisons and Rehabilitation upon recommendation by a Governor in some circumstances. The rules changed in 2009, when the Secretary of State's power to veto release of those serving 15 years or more applying for compassionate release was taken away; this decision now lies with the Parole Board.[130] Its use has been limited in nature and evidence to us suggests that the criteria set out in PSO 6500 are applied very conservatively. Of particular note is the following guidance given with regard to incapacitation:

> Early release may also be considered where the prisoner is bedridden or severely incapacitated. This might include those confined to wheelchairs, paralysed or severe stroke victims. Applications may also be considered if further imprisonment would endanger the prisoner's life or reduce his or her life expectancy. [131]

Prisoners frequently continue to be held in prison when they are bedridden, severely incapacitated or are confined to wheelchairs. Leigh Day pointed to their experience of the use of release on compassionate grounds:

> First, the criteria for early release on compassionate grounds include a provision for those prisoners who are incapacitated or bedridden. However, we are not aware of any older prisoner released on such grounds. Second, the criteria for early release on Home Detention Curfew in exceptional circumstances include a provision for prisoners who are infirm either by age or disability. Again, we are not aware of any prisoner being released on such grounds.[132]

97. The Minister told us that he faces a difficult decision in approving release on compassionate grounds. The public are aware of high profile cases, the release of Al-Mejrahi by Scottish Ministers among them, in which prisoners have been released on the ground of terminal illness but death did not imminently occur. Judging how long a prisoner may live appears to be a difficult task:

128 National Offender Management Service, *Prison Service Order 6000*, Issue no. 226, March 2005

129 *Early release of prisoners in England and Wales,* Standard Note 05199, House of Commons Library, May 2013

130 Prison Reform Trust, *Doing time*, 2010, p.7

131 National Offender Management Service, *Prison Service Order 6000*, March 2005, para 12.4.2

132 Ev 68

> This is the difficult bit because, inevitably, the medical evidence that we are likely to receive will give us an estimate as to how long someone has left. I have to make a judgment as to whether or not that is the appropriate moment for them to be released, effectively to go home to die, because the public would expect me, first of all, to be compassionate in making sure that I allow someone to go home to die if that is what they choose to do, but also to make sure that I am not releasing someone far too early and they end up being outside prison for a very considerable period of time.[133]

We were also told that it is not a simple task to judge the potential of a terminally ill prisoner to breach their licence; sexual offenders may still be considered at high risk of reoffending even close to death. Dr Brew said:

> Governors are understandably very risk-averse when making their decisions about releasing patients, and it has to be recognised that with some older prisoners, particularly those who have been guilty of sexual offences, the risk goes on until they are completely immobile. While, yes, I am in favour of making the application, it is understandable that quite often those are rejected.[134]

98. Despite this there have been calls to extend expected survival time from three months by which a release on compassionate grounds should be considered. The Criminal Justice Alliance and the Prison Reform Trust both advocate extension to a year[135]. Other witnesses argued that Governors were too conservative and risk averse in their application of compassionate grounds and questioned whether end of life care can effectively be provided in all prisons.[136] This assertion may be reflected in the fact that not all prisons have either inpatient facilities or a palliative care suite; at HMP Isle of Wight there were both of these facilities, but at HMP Dartmoor there were neither. Prisoners were able to be transferred to an end of life care suite at HMP Exeter or to local hospitals, but neither of these sites are close.

99. ***Release on compassionate grounds remains a difficult decision for Governors and in some cases the Minister. The extension of palliative care suites is a way to provide effective care within prison, but such provision is not universal.*** **NOMS should provide for more prisons to create palliative care suites. NOMS should add as a criterion to be taken into account in considering the release on temporary licence on compassionate grounds for terminally ill prisoners, whether effective care can be provided in the prison in which they are held or in another suitably located prison.**

133 Q 145

134 Q 91

135 Ev w14 [Criminal Justice Alliance]; Prison Reform Trust, *Doing Time*, 2010, p.7

136 Ev 77 [Age UK]; Q 50 [Helen Boothman]; Q 92 [Dr Brew]

4 Resettlement

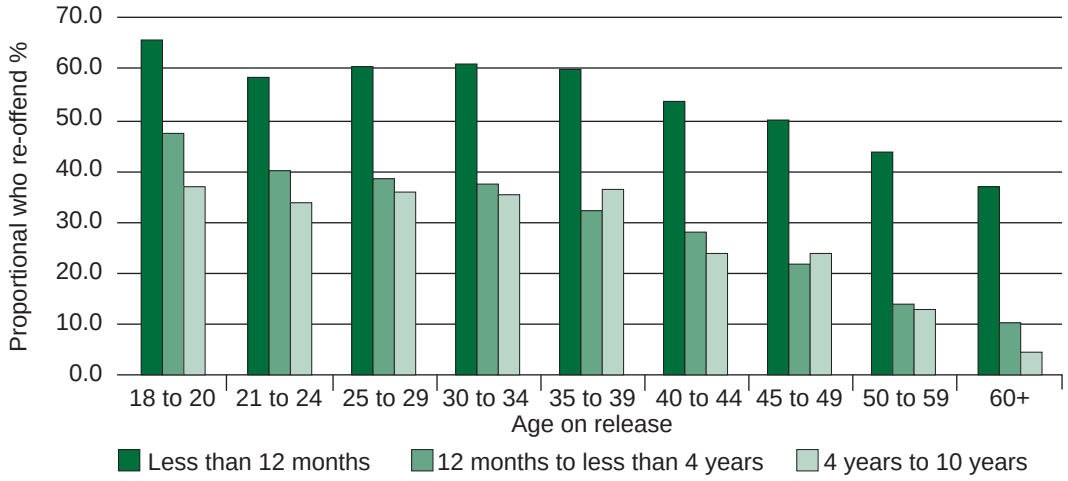
100. Prison Service Order 2300 states that in addressing prisoners' resettlement needs, account must be taken of the diversity of the prisoner population and specific demographics of the prisoner population may be treated in different ways.[137] The Government admits that there are no specific arrangements for the resettlement of older prisoners but as with the rest of the prison population needs are responded to on a case by case basis.[138]

101. Some older prisoners will never be released, but for those who are, particularly sex offenders, the experience can be daunting. Dr Elaine Crawley explained her experiences through research to us in written evidence:

> Anxieties about what release would bring were especially strong for those serving sentences for sexual offences against children. Several of our interviewees said that they had had to flee their homes, leaving all personal possessions behind, because of threats from neighbours to kill them or burn their houses down. In cases where offenders had expected to return home after the court hearing but had, instead, received a prison sentence, they had to rely on relatives or friends to retrieve personal possessions and this was not always possible. In numerous cases where the prisoner had been living in council-owned accommodation, it transpired that the housing office, upon hearing of the prisoner's conviction, had entered the property and thrown everything out, including personal papers and family photographs.[139]

What are the resettlement needs of older prisoners?

Chart III: Proven re-offending rates of offenders released from custody in the 12 months ending June 2011



Data Source: Information provided by the Ministry of Justice at the request of the Committee

137 Ev w28 [Dr Elaine Crawley]

138 Ev 73

139 Ev w28

102. Chart III demonstrates the incidence of re-offending in the prisoner population after release, broken down by age at release. It is clear that across all three sentence lengths shown above, the older the prisoner is on release the less likely they are to reoffend. This is particularly extreme in longer sentence lengths: those released after a sentence of four to ten years over the age of 60 had a reoffending rate of 4.8% in contrast to 36.9% of the 18–20 year old group. The declining likelihood of re-offending draws a clear distinction in the resettlement needs of older prisoners from the younger prisoners. Prisoners over the age of 60 are also more likely to successfully complete their licence conditions; 88.6% in contrast to 76.3% of all offenders.[140] Despite this there is still serious concern that certain older prisoners may re-offend and in particular many older prisoners who were sex offenders will be considered high risk.

103. On our visits and in the evidence that we received we have found that the resettlement needs of older prisoners are distinct from the younger cohorts in other ways too. Staff at HMP Isle of Wight told us that employment-focused resettlement programmes were less relevant to older prisoners who on release would be of pensionable age.

104. The long sentences which older prisoners might have served and the consequential loss of contact with family members contribute to the distinct requirements of older prisoners. Age UK in their guide to supporting older prisoners assert that advice given to younger prisoners is often of little use to people who are retired and who need tailored help and advice.[141] RECOOP help run a diversity centre at HMP Dartmoor with resettlement courses for all those aged over 50 within nine months of release. The course includes advice about managing medication and chronic conditions; how older prisoners can interact with members of the public, how they 'tell their story'; advice about living in approved premises; The Dartmoor over 50s club provides advice about pensions, benefits, bank accounts and obtaining ID. Similarly at HMP Isle of Wight, the Common Assessment Framework pilot ran an older people group in which basic skills like ironing and cooking were taught. These services reflect the often very basic skills that older prisoners need on release. It was commented to us on one visit that after long sentences, older prisoners struggle to even buy food from a shop, let alone access the internet.

Problems in provision

105. The evidence we received has been highly critical of the broader provision of resettlement services inside prison for older people. In both their 2004 and 2008 reports HM Inspectorate of Prisons raised real concern about the lack of specific resettlement help for older prisoners.[142] Only four of the prisons they surveyed mentioned any such services. This was again reflected in Prison Reform Trust research which found that there was no age appropriate provision of resettlement services in two thirds of prisons.[143] More worrying are the findings of the Offender Health Research Network which found that:

140 Ev 73

141 Age UK, *Supporting older people in prison: ideas for practice*, June 2011, p.17

142 HM Chief Inspector of Prisons, *Older prisoners in England and Wales: a follow up to the 2004 thematic review,* June 2008, p.31

143 Ev w43

> Release planning for older prisoners was frequently non-existent. When asked about the plans for release, prior to their discharge, the majority of prisoners simply stated that no plans had been made. It was their perception that their release was not being planned at all. They described that this caused high level of anxiety in the months, weeks and days prior to release.[144]

106. For older prisoners more uncertain destination and a lack of planning for release can cause severe anxiety and psychological pressure at a critical stage in preparation for resettlement. Helen Boothman drew this to our attention and commented on the lack of information available to them.

> Last week, I was having a conversation with an 84-year-old prisoner who just burst into tears because he had had to sell his house since coming into prison, was being released in October and had no idea what was going to happen to him when he was released. That is a classic example of the lack of communication to individuals. If you were in the community, you would go and find the information. There are not the places to go to seek that information and the reassurance that an individual needs. I think that is a worry.[145]

Paul Grainge from RECOOP, who has been commissioned by the Ministry of Justice to build capacity in the provision of services for older prisoners, was equally critical:

> [...] when they are coming out, where they are because of their age—they are old, frail and vulnerable—we are finding that sometimes there is no referral to the social services ... There is little to no pre-release planning for individuals, e.g. a wheelchair user might be released without a wheelchair, with totally inadequate clothing for the time of year, with no information about what support is available on the other side and no guide to being homeless.[146]

107. ***We welcome the resettlement services for older prisoners that are currently provided, especially those which we saw at HMP Dartmoor and HMP Isle of Wight. Services which provide comprehensive plans are the ideal way to provide for successful resettlement, and it is these services that are most important to older prisoners, rather than those relating to employment which may not be relevant and ignore other needs.*** **NOMS should extend provision of resettlement services that are targeted at older prisoners wherever an older prisoner population exists. All older prisoners who are released after a long period of incarceration must have a resettlement and care plan.**

Approved premises and housing

108. On our visits we were told that it is often the case that the housing needs of older prisoners are greater than other parts of the prison population because of the number who have been isolated from the community from which they came. In the case of sex offenders

144 Ev 49

145 Q 63 [Helen Boothman]

146 Q 115

it is a result of the nature of their offence, and their long incarceration has meant that they have had to sell their houses or no longer have a residential base within their home local authority. Prison staff reported to us that in their experience of holding older prisoners frequently all contact had been lost with their family and friends. In 2010–11 the positive accommodation outcomes of over 60 year olds on release were 7% lower than the average of the prison population.[147] The most likely initial destination of older prisoners who have served long sentences, and as a result have grown old in prison is an approved premises.[148] The allocation may be part of an ex-offender's licence conditions; a stipulation might be made that a sex offender is prohibited from residing within a specific area, typically that associated with their original offence.

109. Prison staff and workers from voluntary organisations often have difficulty in securing any accommodation for older prisoners and as a result they are sometimes released to No Fixed Abode (paragraphs 114 to 118 below). In HMP Dartmoor we were told that RECOOP staff went to great lengths to secure places in approved premises or with housing agencies.

110. This difficulty is partially caused, NEPACS told us in written evidence, by the fact that approved premises are the preserve of high risk offenders alone.[149] For lower risk offenders this can present difficulties in finding accommodation; Helen Boothman reported that rules against accommodating sex offenders made this difficult:

> Very often, local authorities and private housing agencies also have blanket rules that they will not accept sex offenders, whether they are low risk or high risk sex offenders. Until that changes and there is more education it will be a major problem when it comes to locating these more mature men out in the community.[150]

111. Others reported that acute anxiety was experience by older prisoners who faced the prospect of residence in approved premises.[151] Many may be worried that their removal from this protected environment to a place in which the broader prison population mix might put them at risk. RECOOP report that older prisoners are seen as "easy targets" in approved premises.[152] Other concerns were raised with us that approved premises were not universally appropriate to hold older prisoners; Sean Humber told us that this had an impact on admissions:

> There is a particular problem with hostels and how compliant they are with disability requirements. Often, prisoners are not able to be released to hostels because the hostels are not able to take them.[153]

147 Ev w43 [Prison Reform Trust]

148 Ev 55 [RECOOP]

149 Ev w62

150 Q 63 [Helen Boothman]

151 Ev 49 [Offender Health Research Network]

152 Ev 55

153 Q 63

112. The Offender Health Research Network reported, however, that the anxiety experienced by prisoners was largely misplaced and that approved premises successfully catered for the needs of older prisoners:

> Once released, anxiety levels were generally reduced, largely as a result of people being generally satisfied with their placement in approved premises, despite their foreboding about it whilst still in custody. Those in approved premises tended to report that their immediate health and social care needs were largely well met. Those residing in approved premises generally considered themselves to be in a transitional period, where they had not been fully released into the community [...] Those who were residing in probation approved premises had fewer unmet needs on release than those who were not.[154]

113. **Approved premises are in principle the right place to hold older prisoners who have no home to go to following a long sentence for serious offences because they provide accommodation from which they can begin to rebuild their lives. *The difficulties which are faced in securing accommodation are particularly acute for sex offenders; problems are compounded by limiting places in approved premises to high risk offenders and licence conditions and housing agency policy limit options for where older prisoners can live.* It is a matter of concern that approved premises may be unable to receive older prisoners because they are not compliant with disability requirements. Probation trusts must take steps to ensure that all approved premises meet disability and age equality requirements.**

Release to No Fixed Abode

114. Release to no fixed abode (NFA), when offenders are released without accommodation to go to, was cited in evidence to us as a significant factor in the failure of resettlement of older prisoners. On our visits to HMP Dartmoor and HMP Isle of Wight we were told that it was a frequent occurrence. The reasons that prisoners are released to no fixed abode are reportedly unclear and have not been quantified. In some cases release to NFA is the inevitable consequence of late or no referral to housing agencies by those responsible for providing for resettlement.[155]

115. The practice seems to affect older prisoners disproportionately because many prisoners who have served long sentences for serious offences no longer have a family home to return to. RECOOP suggest that the form of release sets older prisoners up to fail, and renders any pre-release resettlement work that they provide irrelevant.[156] In discussions with prison staff and staff from RECOOP on our visit to HMP Dartmoor, we were struck by the examples they gave of release to NFA. They were took steps to liaise with local authorities, private housing providers and approved premises, but reported uniform difficulty in securing any accommodation.

154 Ev 49

155 Ev w21 [Nick Le Mesurier]

156 Ev 55

116. In Wales, legislation exists that prohibits release to NFA and evidence to us points to a marked difference in the outcomes of older prisoners on release.[157] Dr Ware gave an example of a direct comparison:

> There are two women who were due for release from Eastwood Park, and return to south Wales, and they were in a group of older women I was recently visiting. The women who were due for release in England were rather envious of the support the other two were going to get when they were released. One of the women in England has been in touch with me, and she is homeless; she is still NFA. The two from south Wales have been housed.[158]

117. We asked the Minister about the practice and he made clear that he expected providers, in most cases NOMS, to liaise with housing agencies who have ultimate responsibility.

> As I say, it is very clear to everybody when they look at the evidence that a lack of a stable address is a clear warning factor as to the likelihood of reoffending. So you will want to make sure that someone is accommodated somewhere stable; if it cannot be in a private address, then I would expect providers to be working with local authorities that are the housing authorities to provide housing through that route.[159]

118. ***We do not doubt that efforts are made to avoid releasing older prisoners to no fixed abode but still occur frequently. Release to no fixed abode undermines all work that has been made towards resettlement and will do nothing to assist older prisoners not to reoffend.*** **Older prisoners, who may be frail and vulnerable, should not be released to no fixed abode because there has been no housing referral, or it has been delayed. NOMS must ensure that all older prisoners who require accommodation are referred to housing agencies within good time. The Government should bring forward proposals to ensure that, as in Wales, no prisoners are released to No Fixed Abode.**

Impact of the Offender Rehabilitation Bill

119. The Offender Rehabilitation Bill, which is currently making its way through Parliament, makes a number of changes to the operation of the probation service. Of particular relevance to this inquiry is the fact that the bill will extend through the gate probation services to offenders serving sentences of 12 months or less and most of those services will be provided by private and voluntary sector contractors whose services will be commissioned under payment by results. The Government has also indicated that it will move to reorganise the probation service into a national structure.

120. Given the high proportion of older prisoners who are convicted for sexual offences it is likely that their longer sentences and categorisation as a high risk will mean that in many cases they will be under the purview of the National Probation Service. There are, however,

157 Ev 55

158 Q 112

159 Q 160

significant numbers of older prisoners who will be the responsibility of the private and voluntary sector. In 2012 there were 2,163 people aged 50 to 59 and 493 over 60 who were discharged from determinate sentences of 12 months or less. The impact of the Offender Rehabilitation Bill on older prisoners from this perspective is likely to be limited. They account for a proportionately low number of discharges for sentences of 12 months or less and a small proportion of the older prisoner population as a whole.[160] The Ministry of Justice, however, suggests that there will be benefit for those who will be affected by the reforms:

> We believe that these proposals will improve outcomes for all, including for older offenders.[161]

121. Equally some of our witnesses expressed their support for the proposals. Paul Grainge, from RECOOP, said:

> What I have read and the fact that we are going to be picking up and supporting those who are serving less than 12 months is a great move. I am conscious that the older cohort has not been defined as a specific group, but I am also conscious that there are very small numbers of older prisoners being released. But the level of crisis they have is huge, so that would be an area of concern.[162]

122. Older prisoners released after sentences of 12 months or less fit most neatly into the group of older prisoners who are chronic or repeat offenders. Their short sentence length does not necessarily exclude them from the exacerbated health and mental health issues which we have found to be typical amongst older prisoners and their needs may differ distinctly from those incarcerated for the first time at an older age. Of prisoners who serve sentences under 12 months, older prisoners are the least likely to reoffend. The resettlement needs of the older prisoner population are broader than just reducing reoffending and include successful access to community services and reintegration into society.

123. **When commissioning resettlement services for older prisoners under payment by results system, the Government must take into account the limitations of reoffending measurements, and should ensure that success is measured according to reintegration and engagement of former older prisoners with community services and society. Older prisoners are unlikely to be seeking employment. They are also, taken as a category and with some exceptions, the least likely subgroup of the prison population to reoffend; their resettlement needs are distinct from the younger population and commissioned services must reflect this.**

160 Information provided by the Ministry of Justice at the request of the Committee.

161 Ev 73

162 Q 97

Continuity of health and social care in the community

124. Continuity of health and social care in the community from that which has been provided in prison involves communication between the prison staff, those who have provided social care and prison healthcare teams. Evidence we have received and our own experience on visits points to practical and structural failures that exist in providing for older prisoners. RECOOP in their written evidence summarised their understanding of the situation as it stands:

> There is a lack of communication and joint working in the transition for older prisoners from prison to the community; statutory agencies appear to work mainly in isolation, only communicating effectively when managing the transfer of an offender's risk between services.[163]

125. A prime example of this is the criticism regularly levelled in evidence to us that older prisoners frequently leave prison without being registered to a GP. Nick Le Mesurier said that there appeared to be no obligation to register prisoners with a GP or a dentist; he suggested that many older ex-offenders could not have the knowledge or necessary documentation to register themselves. This, conceivably, means that individuals who had access to medical care while in prison to provide for complex chronic needs are unable to access them in the community.

126. ***The failure to register an older ex-offender with a community GP after release undermines any productive work that is done to manage or improve their healthcare in prison.*** **All older prisoners, in their preparation for resettlement, should be provided with necessary documentation and instruction to register themselves with a GP in advance of their release; when an older prisoner is unable to do this them it should be done on their behalf by resettlement services.**

127. We have received evidence that has questioned the level of continuity in the provision of social care of older prisoners. Local authorities have a responsibility to assess the social care needs of a person who may require social care on the commencement of their residence within the competence of a local authority. The provision of care from leaving prison until the commencement of these services seems to be a problem. We heard evidence that suggests wheelchair users have been released without a wheelchair.[164] NEPACS also submitted to us an example of an older ex-offender who was released without sufficient support.

> A recent example of an application to the NEPACS grant scheme was from a Probation Officer on behalf of a 74 year old gentleman on life license. He was recalled to HMP Durham from his home in Preston. When due for release in December 2012 he owned no coat or winter clothing since the prison only supply T shirt and jeans. He suffers from severe arthritis in both hands and feet and also has problems with his memory. As he has been unable to work within the prison he has no savings, nor has he any family support. NEPACS were able to supply winter

163 Ev 55

164 Ev w21 [Nick Le Mesurier]

> clothing, but prison staff expressed their anxiety as to his ability to reach a hostel in the North West without assistance. Eventually it was agreed to transfer him to HMP Preston and organise transport from there, but the concern is that he may offend again with a view to returning to the security of a prison environment.[165]

128. The ad hoc way in which this example was resolved may indeed be typical of the way in which older prisoners with disabilities that require significant social care are released. A prison officer who works with older prisoners at one of the prisons we visited commented to us that old and disabled prisoners have to make own way to their destination when they leave prison. Often this may be hundreds of miles from the prison. Prisoners are sometimes given lifts to a local station, and then the prison officer we spoke to arranges for the complimentary service that aids disabled passengers on National Rail to help them. This simple ad hoc arrangement seemed to be an innovation, and we have heard no evidence to suggest that social care in for disabled prisoners on release is widespread.

129. **The local authority to which an older prisoner is being released should be notified of their social care needs in advance of their release. Any requirements that an old or disabled prisoner may have in order to travel home from prison should be identified and the Government should provide clarification as to which local authority is responsible for supporting disabled prisoners immediately on release. We find it inconceivable that there can be any circumstance in which a prisoner who is a wheelchair user could be released without a wheelchair; NOMS must ensure that disabled prisoners retain their mobility on release.**

Health and social care passport

130. We discussed the failure to connect prison healthcare IT systems with community based services in paragraphs 66 to 70 and recognised the tangible damage that can be done to an older prisoner's health through a failure to provide continuity of care. Various projects have involved innovative practice to enhance continuity of care. We saw one of these projects at HMP Isle of Wight; one element of the Common Assessment Framework Pilot developed individual social care passports for prisoners to take with them when they move to another prison or on their release to the community. The passport contains details about the basic and more complex needs which an older prisoner might have. On release details that are held on the passport are shared with the prisoner's offender manager to identify appropriate support to meet the needs identified in the passport. Evidence from the Association of Members of Independent Monitoring Boards points to similar practice in other parts of the secure estate with specific regard to healthcare.

> Elderly prisoners [at HMP Manchester] are now given a certificate upon release detailing any medical condition and treatment given. This can then be handed to their General Practitioner (GP) so that he/she is fully aware of any health issues.[166]

165 Ev w62

166 Ev 60

Dr Start Ware, who produced research on the success of the Common Assessment Framework pilot, told us in evidence that he was working with RECOOP to provide the service in the South West and Hampshire.

131. **The introduction of a care passport similar that which we saw at HMP Isle of Wight is a simple and effective solution to assist in providing continuity of health and social care of older prisoners. Until there is an effective IT system that allows for efficient transfer of relevant information between prison authorities and agencies in the community, such passports should be given to all older prisoners on their release.**

5 A national strategy for older prisoners?

132. There currently is no specific national strategy for older prisoners apart from national guidance contained in the 2007 Department of Health publication, *A Pathway To Care For Older Prisoners*', that recommended the introduction of an older prisoner policy in every prison and provided guidance for the assessment and provision of healthcare of older prisoners. The Ministry of Justice argued that a national strategy is unnecessary:

> The Government does not consider the establishment of a national strategy for older prisoners to be the best way of proceeding. The equalities policy [Prison Service Instruction 32/2011] already makes clear that the particular needs of individual offenders must be identified and addressed. The differences within the group of older offenders (across the other protected characteristics in the equalities legislation, as well as in terms of offence type, sentence length and other factors) are wide and it is not possible to generalise about what their needs are as a group.[167]

In addition to this, the Minister said to us in oral evidence that:

> My reluctance on this is partly based on a fear that, if you have too many priorities, you end up with no priorities at all. Similarly, if you have too many national strategies, none of them mean very much.[168]

133. Nick Hardwick, HM Chief Inspector of Prisons, disagreed with the Minister in relation to a national strategy and advocated its creation:

> We said that in our reports in 2004 and 2008 and have repeated it again now, but they turn their face against that. In particular, given the growth of the older prisoner population, the changes that are happening to the prison estate and the changes that are happening to staffing levels, I would have thought that trying to take a strategic view of the issue would enable them to use resources more efficiently than they are doing at the moment, would be the right thing to do and would be an effective thing to do. The critical thing to prevent this inconsistency of provision is to have a proper strategy to deal with the changes that are happening in the demographics of the prison population.[169]

HMIP found in their 2008 report that of 29 prisons that he had visited only three had an older prisoner policy.[170] Dr Fazel told us that a national strategy was necessary to remedy this:

167 Ev 73

168 Q 118

169 Q 27

170 HM Chief Inspector of Prisons, *Older prisoners in England and Wales: a follow up to the 2004 thematic review,* June 2008, para 51

> The Royal College of Psychiatrists would support a national strategy. Researchers have been calling for this for over 10 years now, so it is something that people have highlighted previously. Part of it also comes out of the fact that some prisons will inevitably have fewer older people in them and so they will not have the opportunity to develop expertise. Therefore, having a national strategy will enable minimum standards to be set; even things like thresholds for when you treat or admit someone or move them to a hospital could be quite helpful. We see that in the rest of medicine. If you have basic guidelines, that tends to generally improve the quality of treatment.[171]

134. Other evidence also took issue with the Ministry of Justice's conclusions. PSI 32/2011, which the Ministry of Justice claims is sufficient to provide for national strategy, makes clear that particular needs of individual offenders must be identified and addressed. Leigh Day, a law firm that has represented older prisoners in a number of cases, and the Prison Reform Trust both note, however, that PSI 32/2011 replaced Prison Service Order 2855, which concerns prisoners with disabilities, that contained a specific chapter on older prisoners: The new PSI does not, and makes no specific recommendations with regard to older prisoners.[172] PSI 32/2011 also removed the mandatory requirements for local disability policies, disability assessments and Disability Liaison Officers, which were previously required by PSO 2855.[173] More broadly, the Prison Reform Trust told us that PSI 32/2011 contained no significant mandatory requirements or minimum standards.[174] ***Older prisoners have needs that are distinct from the rest of prisoner population by virtue of their severity. Such severity warrants specific means of addressing those needs, and PSI 32/2011 does not sufficiently provide for the minimum standards of care and treatment that are determined by their needs and removed minimum standards and requirements that did exist.***

135. ***We also disagree with the Ministry's view that the needs of older prisoners are too wide to generalise about. There is marked commonality between groups of older prisoners that can guide the development of a national strategy.***

136. ***The growth of the older prison population and the severity of the needs of that population, warrant a national strategy in order to provide for them effectively. Some prisons hold high numbers of older people in their establishments and have the incentive to develop an effective older prisoner policy and regime. Others do not, and the older prisoners who are held in these prisons are more likely to receive inequitable treatment as a result.*** **It is inconsistent for the Ministry of Justice to recognise both the growth in the older prisoner population and the severity of their needs and not to articulate a strategy to properly account for this. The Ministry of Justice should produce a national strategy for the care and appropriate regime for older prisoners to provide for minimum standards that produce effective and equitable care.**

171 Q 84

172 Ev 68

173 *Ibid.*

174 Ev w43

6 Conclusions and recommendations

Categorisation of older prisoners

1. We consider that it does not make sense to impose a rigid classification of age, whether over 50, over 60, or over 65 in defining the older prisoner population. We also note the Ministry of Justice's view that it is not possible to generalise about the older prisoner population. However, the duty to treat each prisoner as an individual should not inhibit the identification of common features among the older prisoner population that can inform policy. Otherwise, the needs of older prisoners will continue to be overlooked. (Paragraph 27)

Suitability of the prison estate and regimes

2. While some prisons are making substantial efforts to adapt their facilities to meet older prisoners' needs, NOMS' responsibility to provide for adaptation to the physical environment of the prison to make basic living for older prisoners feasible is not universally met. In some cases it is impossible to make the necessary adaptations. (Paragraph 35)

3. We recommend that NOMS should conduct a comprehensive analysis of prisons' physical compliance with disability discrimination and age equality laws. As part of the ongoing changes to the prison estate, NOMS should determine which prisons simply are not able to make the adaptation necessary to hold older prisoners and it should then no longer hold older or disabled prisoners in these institutions. (Paragraph 35)

4. Many older prisoners are currently being held in establishments that cannot meet their needs. We are not confident that older prisoners are assessed before their entry into prison and, if they are, whether this has any impact on allocation. (Paragraph 40)

5. We accept that for operational and practical reasons it will not always be possible to allocate older prisoners to entirely suitable prisons, but NOMS should, as a rule, not allocate such a prisoner to an establishment that cannot meet their needs. (Paragraph 40)

6. When older prisoners are unable to work, or to engage with the normal prison regime it is important that they have a regime that allows them to be as active and productive as possible. We recommend that NOMS should ensure all prisons have an older prisoner policy that provides age specific regimes for older prisoners. (Paragraph 46)

7. The integration of prisoners of different ages in prisons has potential benefits for all elements of the prison population and management. In general, we do not see that there is a need for the expansion of segregated older prisoner units or wings. This, however, places greater emphasis on the need within the general prison environment

to establish day centres and regimes that provide for the needs of older prisoners. (Paragraph 52)

Health and social care of older prisoners

8. We recognise that some of the difficulties in accessing healthcare experienced by older prisoners mirror the experiences of healthcare of many in the community. Older prisoners, however, do experience particular barriers to accessing healthcare services. (Paragraph 59)

9. For example, cancelled hospital appointments because of a lack of communication between healthcare and prison officers are entirely avoidable and NOMS should take steps to ensure greater coordination between the two. All prisons should follow the Department of Health guidelines as set out in the National Service Framework for Older People that they should have an nurse lead for older prisoners who can develop a specialty in the provision and dedicate time towards the extra practical demands of that older prisoners present as patients. (Paragraph 59)

10. The unmet mental healthcare needs of older prisoners are extensive. The way to combat this is to raise awareness and enhance training among all those in the prison community – to recognise where mental health problems exist and to refer appropriately. We commend the organisations that provide awareness training inside prisons and we urge NOMS to encourage officers to obtain relevant training and consider integrating it into standard prison officer training. (Paragraph 63)

11. In a situation in which clinicians believes that medical treatment warrants a clinical hold of a prisoner, it should not be a challenge for them to obtain it. As long as there are no overriding security concerns then effective provision of healthcare should guide NOMS in the timings of moving ill prisoners. (Paragraph 65)

12. The failure to connect the community healthcare and prison IT systems has a tangible and negative impact on the healthcare outcomes of older offenders when they enter prison, and when they leave prison it disrupts continuity of care. It frustrates prison healthcare teams and exacerbates the pressures placed on them. We share the Minister's enthusiasm for the more effective transfer of information between those who provide services for offenders during their sentence and after they leave prison. This would be of particular benefit to the treatment of older prisoners with chronic and complex health needs. The NHS Commissioning Board and NOMS should work together to connect the prison healthcare IT systems with the NHS in the community, taking into account security concerns. We intend to monitor progress on this matter. (Paragraph 70)

13. The lack of provision for essential social care for older prisoners, the confusion about who should be providing it, and the failure of so many authorities to accept responsibility for it, have been disgraceful. We welcome the fact that clarity of responsibility is provided in section 69 of the Care Bill. Prisoners, like all those who are resident in the local authority in which a prison situated, will qualify for the provision of social care should an assessment of their needs meet eligibility criteria which will be established by regulation under clause 13(6) of the Bill. Clarification is

needed as to how local authorities with large prison populations will be assisted with the funding which will be required for them to provide social care.(Paragraph 79)

14. The Secretary of State for Health must now work with NOMS and the Minister for Prisons and Rehabilitation to develop criteria which effectively resolve the Law Commission's concern that local authorities do not understand the level of care that prisons provide and the specific needs of prisoners. (Paragraph 80)

15. Clarifying statutory responsibility for social care is a welcome step in improving the provision of social care for older prisoners. It is not, however, a sufficient guarantee for effective outcomes. We consider that NOMS should prepare guidance for prisons in liaising with local authorities social care teams, and should issue a Prison Service Instruction specifying the extent to which it expects officers to carry out basic social care. (Paragraph 83)

16. Some local authorities will face considerable pressure on resources in meeting their new responsibility in the provision of care for older prisoners. While the provision of funding for the service is welcome, there is potential for disparity in the service provided by different local authorities. We recommend that NOMS should set out the minimum standards of care it expects for older prisoners with severe social care needs. It should also guide prisons in their coordination with local authorities. NOMS should consider placing social workers in prisons to work with older prisoners and others with social care needs, as in the effective model that we saw at HMP Isle of Wight. (Paragraph 84)

17. Whatever precise model is adopted, assessment of health and social care needs on entry into prison and subsequent review that follows prisoners through their sentence up to and including release rationalises resources and is an effective way of unifying the complex needs of older prisoners. Such assessments should be provided for all prisoners who enter prison at an advanced age, and who age whilst in prison. (Paragraph 89)

18. The Prisons and Probation Ombudsman noted in his report into end of life care that NOMS were undertaking work into developing new guidelines in the use of restraint in clinical environments. This provides an opportune moment to assess whether the balance between security and compassion is sufficiently achieved. It is right that prison management should give guidance about the removal of restraint in cases of terminal illness and we recognise the pressure that prison officers would be under to remove a prisoner's restraints, potentially at the expense of security. The pendulum seems to have swung too far by excluding the exercise of judgement by experienced prison officers in these situations. (Paragraph 94)

19. Release on compassionate grounds remains a difficult decision for Governors and in some cases the Minister. The extension of palliative care suites is a way to provide effective care within prison, but such provision is not universal. NOMS should provide for more prisons to create palliative care suites. NOMS should add as a criterion to be taken into account in considering the release on temporary licence on compassionate grounds for terminally ill prisoners, whether effective care can be provided in the prison in which they are held or in another suitably located prison. (Paragraph 99)

Resettlement

20. We welcome the resettlement services for older prisoners that are currently provided, especially those which we saw at HMP Dartmoor and HMP Isle of Wight. Services which provide comprehensive plans are the ideal way to provide for successful resettlement, and it is these services that are most important to older prisoners, rather than those relating to employment which may not be relevant and ignore other needs. NOMS should extend provision of resettlement services that are targeted at older prisoners wherever an older prisoner population exists. All older prisoners who are released after a long period of incarceration must have a resettlement and care plan. (Paragraph 107)

21. Approved premises are in principle the right place to hold older prisoners who have no home to go to following a long sentence for serious offences because they provide accommodation from which they can begin to rebuild their lives. The difficulties which are faced in securing accommodation are particularly acute for sex offenders; problems are compounded by limiting places in approved premises to high risk offenders and licence conditions and housing agency policy limit options for where older prisoners can live. It is a matter of concern that approved premises may be unable to receive older prisoners because they are not compliant with disability requirements. Probation trusts must take steps to ensure that all approved premises meet disability and age equality requirements. (Paragraph 113)

22. We do not doubt that efforts are made to avoid releasing older prisoners to no fixed abode but still occur frequently. Release to no fixed abode undermines all work that has been made towards resettlement and will do nothing to assist older prisoners not to reoffend. Older prisoners, who may be frail and vulnerable, should not be released to no fixed abode because there has been no housing referral, or it has been delayed. NOMS must ensure that all older prisoners who require accommodation are referred to housing agencies within good time. The Government should bring forward proposals to ensure that, as in Wales, no prisoners are released to No Fixed Abode. (Paragraph 118)

23. When commissioning resettlement services for older prisoners under payment by results system, the Government must take into account the limitations of reoffending measurements, and should ensure that success is measured according to reintegration and engagement of former older prisoners with community services and society. Older prisoners are unlikely to be seeking employment. They are also, taken as a category and with some exceptions, the least likely subgroup of the prison population to reoffend; their resettlement needs are distinct from the younger population and commissioned services must reflect this. (Paragraph 123)

24. The failure to register an older ex-offender with a community GP after release undermines any productive work that is done to manage or improve their healthcare in prison. All older prisoners, in their preparation for resettlement, should be provided with necessary documentation and instruction to register themselves with a GP in advance of their release; when an older prisoner is unable to do this them it should be done on their behalf by resettlement services. (Paragraph 126)

25. The local authority to which an older prisoner is being released should be notified of their social care needs in advance of their release. Any requirements that an old or disabled prisoner may have in order to travel home from prison should be identified and the Government should provide clarification as to which local authority is responsible for supporting disabled prisoners immediately on release. We find it inconceivable that there can be any circumstance in which a prisoner who is a wheelchair user could be released without a wheelchair; NOMS must ensure that disabled prisoners retain their mobility on release. (Paragraph 129)

26. The introduction of a care passport similar that which we saw at HMP Isle of Wight is a simple and effective solution to assist in providing continuity of health and social care of older prisoners. Until there is an effective IT system that allows for efficient transfer of relevant information between prison authorities and agencies in the community, such passports should be given to all older prisoners on their release. (Paragraph 131)

A national strategy for older prisoners?

27. Older prisoners have needs that are distinct from the rest of prisoner population by virtue of their severity. Such severity warrants specific means of addressing those needs, and PSI 32/2011 does not sufficiently provide for the minimum standards of care and treatment that are determined by their needs and removed minimum standards and requirements that did exist. (Paragraph 134)

28. We also disagree with the Ministry's view that the needs of older prisoners are too wide to generalise about. There is marked commonality between groups of older prisoners that can guide the development of a national strategy. (Paragraph 135)

29. The growth of the older prison population and the severity of the needs of that population, warrant a national strategy in order to provide for them effectively. Some prisons hold high numbers of older people in their establishments and have the incentive to develop an effective older prisoner policy and regime. Others do not, and the older prisoners who are held in these prisons are more likely to receive inequitable treatment as a result. (Paragraph 136)

30. It is inconsistent for the Ministry of Justice to recognise both the growth in the older prisoner population and the severity of their needs and not to articulate a strategy to properly account for this. The Ministry of Justice should produce a national strategy for the care and appropriate regime for older prisoners to provide for minimum standards that produce effective and equitable care. (Paragraph 136)

Formal Minutes

Tuesday 16 July 2013

Members present:

Sir Alan Beith, in the Chair

Steve Brine	Andy McDonald
Rehman Chishti	Seema Malhotra
Nick de Bois	Graham Stringer
Mr Elfyn Llwyd	

Draft Report (*Older Prisoners*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 136 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.

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence reported and ordered to be published on 26 March 2013, in the last Session of Parliament, and 18 June.

[Adjourned till Tuesday 3 September at 9.15am

Witnesses

List of printed written evidence

List of additional written evidence

(published in Volume II on the Committee's website www.parliament.uk/justicecttee)

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2010–12

First Report	Revised Sentencing Guideline: Assault	HC 637
Second Report	Appointment of the Chair of the Judicial Appointments Commission	HC 770
Third Report	Government's proposed reform of legal aid	HC 681–I (Cm 8111)
Fourth Report	Appointment of the Prisons and Probation Ombudsman for England and Wales	HC 1022
Fifth Report	Appointment of HM Chief Inspector of Probation	HC 1021
Sixth Report	Operation of the Family Courts	HC 518-I (Cm 8189)
Seventh Report	Draft sentencing guidelines: drugs and burglary	HC 1211
Eighth Report	The role of the Probation Service	HC 519–I (Cm 8176)
Ninth Report	Referral fees and the theft of personal data: evidence from the Information Commissioner	HC 1473(Cm 8240)
Tenth Report	The proposed abolition of the Youth Justice Board	HC 1547 (Cm 8257)
Eleventh Report	Joint Enterprise	HC 1597 (HC 1901)
Twelfth Report	Presumption of Death	HC 1663 (Cm 8377)
First Special Report	Joint Enterprise: Government Response to the Committee's Eleventh Report of Session 2010–12	HC 1901

Session 2012–13

First Report	Post-legislative scrutiny of the Freedom of Information Act 2000	HC 96–I (Cm 8505)
Second Report	The budget and structure of the Ministry of Justice	HC 97–I (Cm 8433)
Third Report	The Committee's opinion on the European Union Data Protection framework proposals	HC 572 (Cm 8530)
Fourth Report	Pre-legislative scrutiny of the Children and Families Bill	HC 739 (Cm 8540)
Fifth Report	Draft Public Bodies (Abolition of Administrative Justice and Tribunals Council) Order 2013	HC 927
Sixth Report	Interpreting and translation services and the Applied Language Solutions contract	HC 645 (Cm 8600)
Seventh Report	Youth Justice	HC 339 (Cm 8615)
Eighth Report	Scrutiny of the draft Public Bodies (Abolition of Administrative Justice and Tribunals Council) Order 2013	HC 965 (HC 1119)
Ninth Report	The functions, powers and resources of the Information Commissioner	HC 962 (HC 560, Session 2013–14)
First Special Report	Scrutiny of the draft Public Bodies (Abolition of Administrative Justice and Tribunals Council) Order 2013: Government Response to the Committee's	HC 1119

Eighth Report of Session 2012–13

Session 2013–14

First Report	Sexual Offences Guidelines: Consultation	HC 93
First Special Report	The functions, powers and resources of the Information Commissioner: Government Response to the Committee's Ninth Report of Session 2012–13	HC 560
Second Report	Women offenders: after the Corston Report	HC 92
Third Report	Transforming Legal Aid: evidence taken by the Committee	HC 91
Fourth Report	Environmental Offences Guideline: Consultation	HC 604

Oral evidence

Taken before the Justice Committee

on Tuesday 23 April 2013

Members present:

Sir Alan Beith (Chair)

Steve Brine	Gareth Johnson
Rehman Chishti	Mr Elfyn Llwyd
Jeremy Corbyn	Seema Malhotra
Nick de Bois	Mike Weatherley

Examination of Witnesses

Witnesses: **Nick Hardwick**, HM Chief Inspector of Prisons, **Peter McParlin**, National Chairman, Prison Officers Association, and **Nigel Newcomen CBE**, Prisons and Probation Ombudsman, gave evidence.

Chair: I welcome Nick Hardwick, the chief inspector of prisons, who is back with us, as well as Peter McParlin, the national chairman of the Prison Officers Association, and Nigel Newcomen, the prisons and probation ombudsman. This is part of our inquiry into older prisoners. Yesterday, some members of the Committee visited Albany prison on the Isle of Wight, which has a large number of older prisoners. Next Monday, a number of our members are going to Dartmoor to look at probably a different picture of how older prisoners are dealt with. I ask Mr Brine to open the questions.

Q1 Steve Brine: Good morning, and thank you for coming along to give evidence to this inquiry. You know the inquiry we are doing and have seen its terms of reference; we have lots of suggestions for things we might look into. Mr Hardwick, do you think there is even a problem on which we as a Committee should be spending our time?

Nick Hardwick: Yes, I think there is an issue to be addressed. You need to caveat that a little. First, it is important not to categorise all older prisoners as a homogeneous group with lots of problems. We meet many older prisoners who, like older people anywhere, are lively, active and alert and want nothing more than what all prisoners want—to be safe, to be treated decently, to have something active and useful to do and to be helped to stop reoffending. When we survey prisoners, which we do as part of every inspection, generally the responses we get from older prisoners are more positive than those we get from the prison population as a whole. Having said that, I think the title of the thematic paper that we did in 2004 and have used subsequently as a benchmark was well chosen: "No problems—old and quiet". I think there is an issue that older people are not likely to complain and raise issues. The Prison Service has to get to grips with the fact that older prisoners, particularly at the older end of the older prisoner spectrum, are the fastest-growing part of the prison population. The Prison Service is now a significant carer for older people with health and social care needs. While, generally, people are content, as I said, that is inconsistent. We think that the service will struggle to meet those demands as time goes on.

Q2 Steve Brine: Mr McParlin, can I ask you the same question? From a POA point of view, is there a problem?

Peter McParlin: You have heard the figures quoted by Nick. The number of over-60s is up by 142% in the last 10 years, which would indicate that there is a problem, but it is not the only problem within the prison estate. In this world of reduced resources and access to resources, where do you place your concerns, and where do you place those resources? There is a promise to the public of a rehabilitation revolution that involves preventing prisoners from returning to custody and giving them access to work outside and training within prison before they return to the outside world, but resources need to be allocated to drug and alcohol issues, of course. Where do you place those resources? Is it a problem? Absolutely. Is it a problem for my members? Of course it is. I have seen some of the evidence from prisoners, not all of which is critical of staff, but there were some criticisms directed at my members. We are in danger of having a situation where my members become, in that hackneyed old phrase, jacks of all trades and masters of none. That is a problem.

Going forward—you would expect me to say this, but it is worth remarking on, as it is a remarkable figure—the prison population peaked at 88,000 and is hovering around 85,000 now. Back in the '90s, when the prison population was circa 45,000, we had more prison officers on duty. People will say, "That is efficiencies. Perhaps we are working in a smarter way." However, with the policies going forward of efficiency benchmarking, those staffing numbers will reduce even further. What do you want the prison staff—the carers—to do? Society and the politicians that represent society have to decide that.

Q3 Chair: You referred to the carers—the prison staff. We will come on to the legal ambiguity around this issue, but how does a prison officer preserve the boundary line between what he is supposed to do as a condition of his employment to make sure that an older prisoner gets out of bed in the morning and the need, in some cases, for a carer who can facilitate the old person getting out of bed and getting washed and dressed?

Peter McParlin: Absolutely. That was highlighted in your seminal work "The Role of the Prison Officer" and is a continuing problem we have to look at. Of course, that is driven from the top. Alongside "Are we warehousing or are we rehabilitating?" is "What is the role of the prison officer?" Is it a multitude of tasks? The main task on behalf of society is obviously to look after those sentenced by the courts—it is security. That is what is drummed into prison staff, and the public would expect that. However, you have to include the issues of caring, because the first person who unlocks that prisoner in the morning is a prison officer. Then we get into issues of training. Do they have the skills? Are we willing to invest in their being able to recognise mental deterioration?

Steve Brine: We will come on to that and probe a bit more. Suffice it to say that some of the prisoners we spoke to yesterday made the point that the cost of security was a huge cost in prisons and they were not the ones who needed so much security.

Chair: They would say that, wouldn't they?

Q4 Steve Brine: That was our feeling. Mr Hardwick, why has the older prisoner population increased so dramatically in recent years? Can you give us some understanding of the technological advances that sit behind that? Do you expect that to continue?

Nick Hardwick: In a sense, this is not something we look at ourselves. Sentencing is not something we look at as part of our inspections, so I am relying on the work of others to answer that. My understanding is that it is not because people are doing longer sentences and, therefore, ageing in prison, and it is not because more crimes are being committed by older people. It appears to be because sentencing is tougher, particularly around sex offences. About 40% of the older prisoner population have committed sex offences. My understanding is that tougher sentencing is the reason behind it.

Steve Brine: Shall we move on? There is a lot to cover.

Q5 Nick de Bois: Can I clarify one statistic? When you gave your quote of, I think, a 500% increase over 10 years, were you thinking of older prisoners as over 50 or as over 60?

Peter McParlin: The figure was for prisoners over 60, as the fastest growing segment. Of course, I am aware that there is some academic discussion about where to pitch the age—whether it should be at 50, 55, 60, and so on.

Q6 Nick de Bois: All right, we will press on; I will not belabour the point, but thank you for that. I want to talk about the prison environment, if I may. Mr Hardwick, can I ask you specifically to what extent the age, condition and infirmity of older prisoners are and should be taken into account when deciding in which category of prison they should be detained?

Nick Hardwick: We would say that categorisation needs to be based on the circumstances and risks of a particular individual prisoner. If, for instance, someone is infirm because of their age and is less mobile, I would have thought that that must have some bearing on their security risk, for instance. Age in itself should not be a factor, but many of the characteristics that go with age should be.

Q7 Nick de Bois: If the environment in some prisons is considered quite unsuitable for certain infirmities or, as you say, it is less likely that someone over 60 will leap over a 30-foot wall or something like that, are you aware of whether that is actually taken into account?

Nick Hardwick: I have not seen any evidence of that. On the contrary, in prisons you go to, the physical needs, in particular, of older prisoners do not seem to be taken into account in the prisons. You often find them in very unsuitable locations.

Q8 Nick de Bois: Mr McParlin, do you think it should be taken into account? Could I ask you specifically if you have any views from a staff perspective—perhaps even reflecting a prisoner's perspective—on whether it is preferable to hold older prisoners in one unit, separate from other prisoners? I am really talking in the context of the environment of the prison.

Peter McParlin: Your first question was about whether it should be taken into account. In an ideal world, of course it should, but the head of NOMS, Michael Spurr, is on record as saying that he lives with—"supports" is perhaps not the right word—institutionalised overcrowding in our prisons, despite the fact that they are closing prisons at what I would say is an alarming rate, which is making the overcrowding even worse. I would say that the issue should be taken into account, but the institutionalised overcrowding to which he refers makes it virtually impossible to do that.

You asked whether they should be held in one unit. The idea certainly has merit. There is no joined-up thinking or policy that I can see, but there will be some examples where they have tried to put them together or had an area where they could meet during the day. Of course, it comes down to the fabric of the buildings and what you are able to work with.

Nick Hardwick: May I add something very briefly? First, there are some prisons that, because of their age and design, are not suitable for older prisoners, particularly those with mobility problems. However, generally older prisoners should be treated in the way in which older people might be treated in the community. They should not be cut off from the population as a whole and should be in prisons with prisoners of other ages, but they should have places within those prisons to go where their specific needs can be met during the day. Many prisons now have a day centre-type facility. That seems to me to be a good thing. Perhaps a wing could be set aside for older prisoners where it is quieter and they can escape some of the hurly-burly that you might get on a general wing. I would not have specific prisons for older prisoners, but I would have facilities within the prison estate as a whole that meet their needs, and I would say that some prisons are not suitable for older prisoners.

Q9 Nick de Bois: While we are on that subject, are there any other changes that you would suggest should

be made to the physical environment in which older prisoners are held? That is my final question. I will open it to all three of you, but perhaps Mr Hardwick would like to offer some more suggestions.

Nick Hardwick: I will look at some of the good practice I have seen. For instance, I quoted in our submission the example of Leyhill, which has a significant proportion of older prisoners. There was a very good day centre facility there, where older prisoners could go during the day and have some activity. I think they were easier to manage there than in other places. I do not think that was a particularly expensive or resource-intensive thing to do. Other prisons have set aside wings that are quieter. In particular, prisons should think about where they place older prisoners, so that they can have easy access to things like showers and toilets; if they are up on a landing with a flight of stairs, they cannot easily move. A bit of thought about those sorts of practical physical adjustments is sometimes important.

Nigel Newcomen: Good morning. Perhaps I could add a couple of words. Obviously my perspective is from the mournful responsibility of having to look into deaths in custody, so it is difficult to generalise about, for example, the particular needs for reasonable adjustment that apply to the broader older prisoner population, but there are all too many occasions when my investigations have recorded and recommended that there should be better reasonable adjustments. For example, the provision of mattresses that can prevent bed sores and of some very basic reasonable adjustments is not consistently applied. In various investigations, I have recommended that that should be the case. Equally, some of the social care provision the Committee may come on to is also inconsistent. That is one of the overarching messages that comes through both from my individual investigations and from the more general learning lessons agenda that I have sought to establish. Things have improved, and it is generally recognised that the adequate care of older prisoners is a problem and a growing issue, but the response remains inconsistent. It is the outliers that are the real concerns in the investigations I undertake.

Q10 Nick de Bois: We are coming on to that. I was thinking more of the physical environment. Mr McParlin, do you have anything to add?

Peter McParlin: Once again, in an ideal world, we would want accommodation that provided wheelchair access; we might even look at lifts, where necessary. I would argue that we will probably not get that in the older part of the estate, but there is a new-for-old policy. There are positives and negatives from that. You would like to think that they would take account of those issues, if we accept that it is a problem. Perhaps initially a directive could go out that they should avoid sending prisoners to certain prisons where the fabric of the building is inappropriate for their needs. That goes back to overcrowding, the issues of allocation and the pressures on the system.

Q11 Nick de Bois: Presumably, you would welcome any opportunity to input these points of view into any new builds. It is important to do that as well.

Peter McParlin: Yes. Arguably—depending on the nature of the offence—given the age and infirmity, if I can use that word, of certain groups of prisoners, it will not be that staff-intensive.

Q12 Seema Malhotra: I am thinking about the prison regime and staff training. The MOJ has said that it is committed to providing a regime "which includes age appropriate activities". However, as has been alluded to, that requires that staff have specific training in dealing with older prisoners. In your opinion, do prison officers receive sufficient training to support older people in prison?

Nick Hardwick: No, I do not think so—not on a consistent basis. Frequently, we find occasions where prison officers simply are not alert to or aware of the needs of older prisoners on their wing. For example, as Mr Brine will be aware, we quoted an example at Winchester prison of two older prisoners with very significant mobility needs. The officer who worked on their landing, who knew those prisoners and was responsible for them, had not thought about the difficulties they would have getting opportunities to shower, so they had not showered for some period of time. That was a question not of any in-depth training but of helping that officer think through the needs of what was becoming a different population, perhaps, from the one she was used to. I do not think this is some huge great exercise—it is an awareness point. There may be some need for more specialist training—the development of champions—in prisons where there are a significant number of older prisoners and things such as mental health and dementia may be issues. That might need a particular skill set. For most officers, it is about awareness as much as anything else.

Q13 Seema Malhotra: Mr McParlin and Mr Newcomen should feel free to come in. The MOJ has been saying that the availability of guidance and information is more important than training. Do you believe that that is the case? Do you believe that would be sufficient?

Nick Hardwick: I do not think it is an either/or thing. Guidance and information would be helpful, but you do not know what you do not know. Unless prison officers are encouraged to be alert to the needs of older prisoners and to think about how these things might be different, they will not look at the guidance and information that will be available. So I think it is both.

Peter McParlin: I come back to the point I made earlier. What do we want? Do we want a professional Prison Service or do we want a fly-by-night operation in which staff stumble along and may have had some documentation pushed in front of them to say that they should be aware of that and it is common sense? A lot of prison officering is common sense, but, if we are saying that this is a problem and we want them to recognise it, you have to give them the tools. They can recognise issues with mobility, but, if they have to start recognising issues with dementia and Alzheimer's, perhaps we need a little bit more input from the centre in the training modules than just a bland piece of paper that says, "Perhaps you should

be aware of this." I think that would prevent some problems going forward. From the point of view of prison officers and the POA, there seems to be a marked reluctance to invest in training staff.

Nigel Newcomen: Can I repeat my previous point about inconsistency? I think that it applies in this context as well. There are some examples of quite good training for staff. For example, in the north-east prison cluster, the Prison Service, the NHS and the Macmillan cancer charity have to date trained some 90 health care and prison staff in palliative care, which is a pretty specialist area of care. That means that there are now some good examples—champions, if you like—of the sorts of care needs that will be required going forward being addressed by training.

Q14 Seema Malhotra: You make a very good point about health care and the specific training that those involved in it receive. There is also a question about the extent to which there is a joined-up approach to dealing with older prisoners' needs. There is one example of a prisoner who described that, when nurses did an assessment of his health and needs, they said that he must not work in workshops or any place where he was in danger of falling, and that he should be put in education. The wing officers put him in a workshop and said, "If you don't go to work, you will lose all privileges." To what extent do you think that that is a common experience and that there needs to be a reorganisation of how a prisoner is dealt with as a whole person across the different departments?

Nigel Newcomen: As I said, it is hard for me to generalise from my particular responsibilities now, but I would stick with my previous point that I find inconsistency too frequently in investigations that my office undertakes. For example, I think the ability of staff to intervene in the appropriate places is stymied by a lack of training and of consistent understanding of some of the needs that prison staff are now being required to manage in 21st-century Britain.

Q15 Mr Llwyd: Good morning. In Wales, prisoners receive their health care via local health boards, which have a continuing responsibility for prisoners within the estate—directly with three prisons and indirectly with another, where there is a commissioning arrangement. The Prison Reform Trust has said that it is not yet clear how the new commissioning arrangements for prison health will work for those needing specialist care. Do you wish to comment on that?

Nick Hardwick: The Prison Reform Trust is correct in saying that it is not clear at the moment how all these arrangements will work in England. The new NHS Commissioning Board with responsibility for offender health has been in place only since the beginning of this month, so there is still a lot to be worked out about how that will happen. As in the population as a whole, the connection between health and social care and how those borderlines are dealt with is still a very acute problem. There are issues in a prison context, particularly on the social care side. If, for instance, the principal local authority is responsible for social care, the danger is that the prisons will no longer feel responsible for that, so their responsibility will be taken away, whereas for the social care provider there is a risk that it will be out of sight, out of mind, and prisoners will be low down the list of priorities. There are risks, in terms of social care, of older prisoners slipping through the gap. Any changes to the arrangements need to be thought through very carefully. In both health and social care, it is still early days.

Q16 Mr Llwyd: Mr McParlin, do you have a view on this? I can see you writing away furiously.

Peter McParlin: I am often in danger of reflecting back and looking through rose-tinted glasses; I apologise for that. I will not say that everything was wonderful in the past, when we had prison health care; of course it was not. However, we did have something called the prison officer nurse, who was a trained prison officer who specialised in nursing and went away for what my memory tells me was a two-year course in nursing. Of course, they were then able to do the security aspects and to care for prisoners. They took that away and said, "We have to replicate what we have in the community"—health care inside should be the same as health care outside. I have to say that, to date, despite some well-meaning staff and some great effort, I wonder whether we have achieved that. There is a counter-argument to that. If I want a medical appointment with my doctor, I will probably have to wait a week, whereas in prison you would probably have access to a doctor on a daily basis. Obviously there are issues with more specialised treatment—dentists, opticians and so on. At the moment, I think it is a bit of a mess.

I will pick up on what Nick has said. The governor of a prison is unsure of where he sits and what his responsibilities are. There is the issue of the national health service outsourcing certain aspects of care, which is causing a problem. Who is responsible for them? If something goes wrong within the prison, where does that sit with the investigations and so on? At the moment, we are falling a little bit between two stools. There is work to be done.

Q17 Chair: Can I clear up a factual point with Mr Hardwick? It slightly anticipates something Mr Chishti will refer to later—what the future arrangements will be. The understanding we gained yesterday is that in a number of prisons—perhaps most prisons—there are no carers. Personal social care, if it is provided at all, is provided as an adjunct to what the prison officer is doing or by hospitalising people in a prison hospital and using the nursing service in the hospital. Some prisons appear to have professional carers doing that kind of work, but many prisons do not have them at all. Is that correct?

Nick Hardwick: That is correct; that is what I understand. Nevertheless, generally the prison understands it is responsible for the social care of the older prisoners it holds. How well and effectively it does that is a different matter. In some cases, prisons do it well; in others, they do it badly. My concern is that, if prisons feel that that responsibility has been removed, we will go backwards rather than forwards. There is a risk that, if there is an external provider, with pressures on their budgets and resources,

prisoners whom they do not see, with whom they are not in regular contact and whose families are not harassing them, may be very low down their list of priorities. My point is not that that should not happen but that it needs to be thought through and planned very carefully.

Q18 Mr Llwyd: To what extent do elderly prisoners receive an equivalence of care to what they would have if they were out in the community? Mr McParlin has referred to that particular matter. If you have a different view from him, perhaps we could hear it.
Nigel Newcomen: I refer the Committee to a couple of reports I passed on. One was a thematic report looking at natural-cause deaths that were investigated by my office; this was published last year. Going back to my thesis that things are improving but in a very inconsistent and piecemeal way, one of the interesting points that the theme suggested on quite a substantial sample of 402 deaths was that there was a statistically significant correlation between the length of sentence and age of the prisoner and the equity of care that was provided. We have clinicians who jointly investigate deaths with my investigators and make a formal assessment of the equity of care with that in the community. It appears that there is some evidence that, as you get older in prison and get ill in prison, access to health care starts to improve and starts to become equitable. However, as I said at the beginning, it remains variable. Certainly, I am looking through a particularly mournful prism—only at those cases where death has occurred, when one would expect there to have been a medical intervention on the route.
Chair: At this point, I turn to Mr Johnson, who will look at some of the issues that you have raised.

Q19 Gareth Johnson: You as ombudsman carried out an investigation, finishing last year, into end-of-life care. What kind of response have you had to that investigation? I think you looked at the number of people who had died in prison and broke it down statistically in terms of age, groupings and so on.
Nigel Newcomen: In terms of response from, for example, the National Offender Management Service, there has been very little, but, in terms of more generally trying to put on the table some learning that, I hope, will gradually be undertaken by the Prison Service and the other authorities that I investigate, I hope it will have a lengthy shelf life and be a slow-burner in encouraging improvement and change. The end-of-life thematic is different from the one I have just referred to. It was still quite a substantial sample—200 or so cases where reasonably foreseeable death was likely to occur. Again, it was interesting that the clinicians who helped to investigate those deaths concluded that, in the majority of cases, there was equitable care with that which would have been expected in the community. However, there were a large number of cases where provision was not consistently good. End-of-life care planning, which is the mechanism by which you get a holistic approach to end-of-life preparations, was absent in a quarter or so of cases. Involvement of the family—something that prisons are still not really familiar with—was poor. There was insufficient early application for compassionate release, so the possibility of dying in the community was not adequately explored. The issue that did not totally shock me but certainly raised my concerns was that there has been an inadequate response to the shackling or restraining of terminally ill prisoners, which needs to be addressed. I hope that this learning lessons thematic and associated materials will encourage change and a positive response, but I fear that it will take time.

Q20 Gareth Johnson: As a result of your investigation, is there one lesson that you think the Prison Service needs to learn about dealing with end-of-life care? Is there one crucial thing that needs to be done that is not being done at the moment?
Nigel Newcomen: Better and more comprehesive planning, so that end-of-life care planning is applied in all appropriate cases.

Q21 Gareth Johnson: That is interesting. Mr McParlin, in your role, can I ask you a question about a controversial issue—the use of restraints on anybody who is receiving medical attention, but on older prisoners in particular? There is obviously a balance to be struck between dealing with people in a respectful, sensible manner and security aspects. What is your opinion on the use of restraints? Where, if anywhere, are we going wrong at the moment?
Peter McParlin: Staff—prison officers—used to have discretion in these matters. They were able to make a judgment when they got out to a hospital and would have discussions with the medical staff. Obviously they would have a look and do a risk assessment of the building as well, but they would be able to use their discretion. It is some years since that discretion was taken away from them. Decisions on restraint come from management, and management is risk averse in this situation. Certainly, NOMS does not want to see any escapes whatsoever, in the tick-box culture that it has. If ever someone escapes, it will have to answer questions from Chris Grayling or Jeremy Wright at the Ministry of Justice, who do not want to see any escapes on their watch and the attendant publicity that goes with that, depending on the type of offence the prisoner has committed. Hence, prison officers have no discretion whatsoever to remove restraints at a hospital bed.

Q22 Gareth Johnson: But, if you give the prison officers discretion, do you not then get an inconsistent approach?
Peter McParlin: That is potentially an issue. However, it would be useful to have a look at the figures, if the Ministry of Justice or NOMS were able to produce them, to see the incidences of absconds/escapes from hospitals—we will use that example—of people who may be in there because they are seriously ill or at the end of life. I agree with you. I assure you that prison officers are placed in an invidious position when they are in a hospice or hospital and are told by management that the restraints cannot be removed when those prisoners are being visited by family. It is an awful situation for my members, but that decision is taken out of their hands.

They have no discretion whatsoever. Otherwise, if something went wrong or there were some issue, they would be the ones who would lose their jobs. Also, when they are visited in that situation by a managerial grade, if those restraints are not applied, they face disciplinary action that, more often than not, leads to dismissal.

Q23 Gareth Johnson: Finally, I will pick up on something that was mentioned by Mr Newcomen—the potential of using more early release decisions to cater for end-of-life care. I suppose there are some obvious concerns that the court of public opinion will have about releasing people who were given life terms, because of the interests of the victim and so on. Do you see any additional barriers to using early release in more instances for people who have terminal illness? Mr McParlin, would you like to comment?
Peter McParlin: I am sorry; is that question to me? I thought you said it was for Mr Newcomen.
Gareth Johnson: I should have been clear about that. I was just referring to something that Mr Newcomen said earlier about increasing the instances of early release for people with terminal illnesses. Do you think there are any additional barriers to doing that, apart from some of the obvious situations?
Peter McParlin: I imagine that there is an issue due to the notoriety in certain cases. We had a great train robber released some years ago, didn't we? We were told that he was at the end of life, and I understand that he is still going strong, God bless him; we wish him all the best. You would like to think that a compassionate approach would be adopted by the people who make those decisions. It would be remarkable to me if someone said that we did not adopt a compassionate approach and did not judge each case on its merits. In fact, I would be horrified if that were not the case.

Q24 Jeremy Corbyn: I go back to Mr McParlin's point about the use of restraint on prisoners and your concerns about this, particularly for older prisoners. Has this been raised at national level with the Home Office, because of the threats of disciplinary action against your members?
Peter McParlin: Yes, we have certainly had those discussions, but the message from the employer is clear—there is no discretion whatsoever. You have to follow the last instruction, which is the risk assessment that was made. It is an all-embracing risk assessment that restraints will not be removed, unless a decision is made back in the prison. However, that can take time, may need a visit from a manager and so on. In an end-of-life situation, in particular, that is appalling.

Q25 Jeremy Corbyn: At a practical level, do senior managers or governors ever attend the interface between a family visit and a prisoner under restraint, when the prison officer is presumably getting it in the neck from the family because of the condition in which the prisoner is being held? Is that kind of support level given?
Peter McParlin: If you are in a hospital situation, which is classified as an escort, I would expect there to be a visit from a senior manager, but it would happen infrequently. It is there to attempt to catch the staff out—to see whether the staff are doing something that they should not be doing. As a trade union leader, I would say that, wouldn't I? We do get visits from managers, but they are infrequent.

Q26 Chair: Mr Hardwick, did you want to say something?
Nick Hardwick: Our experience is that, if you have a situation where someone is in end-of-life care, governors will often meet family and relatives as part of that process, for genuinely humane reasons. They are less likely to be involved if you have a sudden emergency—for instance, if somebody is injured or becomes ill very suddenly and has to go to hospital. The governor is less likely to be present at that sort of incident when the question arises of whether the prisoner will be required to be in restraints. However, we have seen governors present at longer-lasting incidents and for more positive reasons than talking about restraints.

Q27 Mr Llwyd: What has just been said quite shocks me. We have not learned much since the '92 Parliament, when pregnant women were shackled to beds when they were being delivered of babies. God! Excuse me. I have one final question for Mr Hardwick. Why have prisons been rather slow to respond to your recommendations and those of the national service framework for older people? What do you think they should prioritise?
Nick Hardwick: We think that they need a national strategy for dealing with older prisoners. We said that in our reports in 2004 and 2008 and have repeated it again now, but they turn their face against that. In particular, given the growth of the older prisoner population, the changes that are happening to the prison estate and the changes that are happening to staffing levels, I would have thought that trying to take a strategic view of the issue would enable them to use resources more efficiently than they are doing at the moment, would be the right thing to do and would be an effective thing to do. The critical thing to prevent this inconsistency of provision is to have a proper strategy to deal with the changes that are happening in the demographics of the prison population.

Q28 Rehman Chishti: I return to the question of social care. I know all my colleagues on the Committee have touched on it briefly already, but I have a few specific questions. First, in your experience, how would you describe the current provision of social care to older prisoners?
Nick Hardwick: I think it is inconsistent. We see very good examples at Leyhill, but we also see examples of things that are very concerning. The other day, I was in a prison where no care was provided for a prisoner with severe mobility problems. As a consequence, he was having to make his own arrangements to get other prisoners to fetch his meals for him. He was then being bullied and intimidated by

the people he was asking those favours of. There was no formal social care for him, so that ad hoc arrangement was placing him at risk. We see very good things and very bad things.

Nigel Newcomen: I can endorse that. We see exactly the same in the investigations we undertake. For example, there are occasions when prison officers display remarkable fortitude in terms of the social care provision that they are prepared to undertake. In some cases, it is a formal provision by local health authorities. In other cases, it is dependent on individual prisoners. In my last annual report, I recorded a case where a prisoner complained of being completely traumatised by the approach that was required of him to look after the continence needs of a dying prisoner. I think provision is inconsistent and lacks coherence. It needs to be looked at in a way that draws in community health providers, the Prison Service and, indeed, staff associations as to what is going to be provided in what is going to be an increasing area of demand in the prison context.

Q29 Chair: Yesterday, we found that there were positive aspects to those prisoners who were able to help other prisoners doing so, but there is also a very significant supervision requirement, not least because in this prison generally you were dealing with sex offenders.

Nick Hardwick: That is absolutely right. Prisoner buddies or orderlies providing support in a properly regulated and supervised scheme is a very positive thing; we have seen examples of where it works well. My concern was that an informal arrangement, where an individual older prisoner has to go to whoever happens to be on the wing and beg favours of them, exposes them to real risk.

Q30 Rehman Chishti: Would you not agree with what has been said by the Prison Reform Trust—that there is a lack of clarity of responsibilities and "confusion over provision of daily living aids, personal care and occupational therapy"?

Nick Hardwick: Exactly. One thing is that local authorities now have safeguarding responsibilities for older or other particularly vulnerable prisoners. We now look at what prisons are doing to ensure those arrangements are in place. Almost nothing is happening with regard to that responsibility. That is a big gap.

Q31 Rehman Chishti: I move to Mr McParlin. How confident do prison officers feel about providing social care?

Peter McParlin: I will pick up a word that seems to be popular—they feel inconsistent, if that is the proper word. Very few prison officers do not want to do their best. They want to do their best for society and for the prisoners in their care, but they need to know what they are expected to do and to be pointed in the right direction. They need that support and, I believe, proper training.

Q32 Rehman Chishti: Do you agree with the Government's proposed approach to resolving these issues, which is to give local authorities a statutory responsibility for assessing the needs of, and providing services to, prisoners?

Nick Hardwick: As I said, I think that needs to be dealt with very carefully. My fear is that, if, at a time when there is pressure on resources in prisons, the prisons feel that that responsibility has been taken away from them, they will not do anything. We know how difficult it is to get local authorities to provide appropriate care for people who are living in the community and have relatives actively working on their behalf, so there is a danger that, with prisoners, it will be out of sight, out of mind, and the situation will deteriorate. That is an issue that needs to be approached very carefully. The risks I have just spoken about need to be thought through and addressed.

Q33 Rehman Chishti: We also have a view from the Prison Reform Trust, which said, "We would like the local authority in which the prisoner is located to hold responsibility for commissioning social care in that prison, as currently happens with health care."

Nick Hardwick: As I said, I would be cautious about that. I do not agree with what Mr McParlin said earlier about health care. I think that, as a whole, the arrangements for health care have improved health care for prisoners, but the social care issue is different.

Nigel Newcomen: I feel there is a repeated theme—that we must seek to avoid the risk of inconsistency. The possibility and prospect of at least having a formal responsibility offers some glimmer of hope of consistency but, in the context of the competing pressures that will be found in the different authorities, we may not move much further forward. I fear that this is an area that will continue to grow in the context of prisons.

Q34 Rehman Chishti: The Prison Reform Trust says "as currently happens with health care". It would not say that unless it had looked at the issue and decided that health care provision by way of local authority commissioning works.

Nick Hardwick: I am not saying it is wrong; I just think it needs to be thought through carefully. If you have a health care complaint, generally speaking that is a visible or obviously demonstrable problem and there is a place you can go to—a health care centre where that issue will be attended to. The problem with social care is that it is not provided in one location—it is something that the whole prison needs to be involved in providing at one level. Sometimes, the needs are not as obviously visible as they might be for a health issue. That is why I think that, if the responsibilities are not really clear, there is a danger that things will fall through the net.

Q35 Chair: They are not clear now, are they?

Nick Hardwick: No, they are not, but at the moment it is clear that the governor of the prison has a responsibility to provide care for all of the prisoners he or she is responsible for. The risk is that, in a time of resource constraints, if you say to the governor that somebody else is responsible for providing care for this group of prisoners, they will say, "All right, I will shift my resources to where the responsibility is solely

mine." However, the local authority, which is responsible for this group of prisoners, may not be as on top of, and aware of, their needs, because they will be out of sight and more difficult to have access to, and because the local authorities themselves are under pressure. I think there is a risk—I do not see it as more than that—in these new arrangements, if they are not thought through carefully, of prisoners falling between the cracks.

Chair: Thank you very much. We are grateful for your help this morning. We have some further witnesses.

Examination of Witnesses

Witnesses: **Helen Boothman**, Secretary, Association of Members of Independent Monitoring Boards, **Sean Humber**, Partner, Leigh Day, and **Dr Azrini Wahidin**, Reader in Criminology and Criminal Justice, Queen's University, Belfast, gave evidence.

Q36 Chair: I welcome Helen Boothman, the secretary of the Association of Members of Independent Monitoring Boards—what we used to call prison visitors, which was a lot easier to say; Sean Humber, who is a partner in Leigh Day; and Dr Azrini Wahidin, who is reader in criminology and criminal justice at Queen's University, Belfast. We are very grateful to you for coming in to help us with this inquiry. To what extent is it possible or appropriate to treat older prisoners as a distinct group rather than as individuals with different kinds of needs?

Dr Wahidin: It is important to consider two things. First, we have an ageing prison population that is growing rapidly—faster than any other cohort within our prison population. Currently, we do not have a national strategy to deal with this group. We do not have age-specific guidelines within our prison estate. The first issue is to have guidelines and provisions that are age-specific, as we do in other jurisdictions. I have been working in this area since 1996, on both sides of the Atlantic, and have just come back from Australia. I have been looking at palliative health care that deals with older offenders with specific health and social care needs. The units begin at the age of 50 to 55, because we are well aware—the research demonstrates this—that our older prisoners are suffering from what is known as accelerated biological ageing. That means that they are 10 years older than their peers on the outside. On one level, we have to deal with them as a homogeneous group, but we must also have specific regimes that deal with individual offenders and relate to their specific needs.

Q37 Chair: Of course, you have to bear in mind that the phrase "ageing prison population" is slightly misleading. It is not that we just have so many people in prison for so long. We have some people in that category, but a very significant proportion of the population we are talking about are people who have lived in the community for most of their lives and have been arrested and given substantial prison sentences for very serious sexual offences, which means that they come new to prison in an older age range. That is one example of a group that might require looking at differently than people who have been in and out of prison all their lives and have come back again.

Dr Wahidin: Or those who have grown old in prison. As we know, our over-50 population comprises roughly 11% of the prison population—just under 10,000. You are quite right that we have those who are coming in as older offenders for the first time to serve a very long sentence. However, we need to have some type of framework in place that deals with our ageing population and older group, because currently they are invisible.

Q38 Chair: When talking to both prisoners and staff, we have found that there are differences of view among older prisoners about whether they want to be in an older prisoners' unit or whether they want to have some younger people around. Do you have views on that issue?

Helen Boothman: I do not think there is one size that fits all. You can look at the pros and the cons, but IMB reports up and down the country show that there are more positive comments about being together than about being integrated into the mainstream population, the reason being that often mainstream prison wings are very noisy. More mature men tend to like quieter places. Even things such as running in the corridors, which came up at an older prisoner forum that I attended the other day, have become an issue; that is why they wanted something where they could all be located together. I know you have talked about the physical side of prisons, but, if they are in a unit together, the physical provision can be provided much more easily. It can also be located in a place that gives them access to visits or the library. Again, it just reduces the feeling of isolation that they often have. Generally speaking, I think there are more pros about being together than cons.

Sean Humber: I agree. Obviously, older prisoners are not an entirely homogeneous group, but none the less they tend to have many common features—health issues, disabilities, vulnerabilities and so on. A common strategy is required to look at those. From talking to clients, I do not think they have to be completely separate; you do not want to have prisons simply for older prisoners. However, we should be going in the direction of having distinct parts of prisons where they can go and associate with older prisoners—day centres and so on.

Dr Wahidin: I endorse the views of both previous speakers. From research that I and a colleague of mine, Professor Ron Aday in the States, have conducted, we have both come to the conclusion, with practitioners in the field, that older offenders, both male and female, favour integration, with special designated facilities for older offenders to access.

Q39 Jeremy Corbyn: My question is for all of you, but I guess that Mr Humber will probably want to answer first. To what extent does the provision provided to older prisoners by the Prison Service comply with equality and human rights legislation? It would be helpful to us if you have any experience of taking cases beyond the UK orbit—to the European Court of Human Rights, for example—on older prisoners' conditions.

Sean Humber: Unfortunately, our experience is that many prisoners do suffer unlawful discrimination. Historically, it was on the grounds of disability and their failure to participate fully in many aspects of prison life, so that they lived a very isolated, excluded existence. The age provisions are newer and have been in effect only for the last generation of services, but it is likely that there will be an increased number of claims of age discrimination on the basis of older prisoners not being able to participate fully in prison life.

My experience of disabilities over the last 10 years—which is instructive, in a way, when we look at the issue of age discrimination now—is that there has been a real lack of strategic analysis of disabled prisoners within the prison estate. I have had a succession of prisoners over the last decade who have suffered problems. There has clearly been a failure to make any reasonable adjustments and, frankly, we would say, an ignorance of the law—of what is required. The problem is that it has always been done on something of an ad hoc basis and there has been very little strategic oversight even of the number of disabled prisoners, the types of disability and the number of disabled facilities.

I can see that problem recurring now in relation to older prisoners. Some prisons are doing a better job than others, but there is no real analysis. I refer to the issues discussed by the previous witnesses. Should this prisoner even be starting off in this prison in the first place? Should it be up to that prison to try to duck and dive and to do deals to work out whether the prisoner can go to another prison? Where is the strategic overview? That is the context. It is not all absolutely about resources, but it has to be said that there is a lack of disabled facilities across the prison estate. However much that can be better managed, it is a fundamental problem.

Q40 Jeremy Corbyn: Have you taken out any cases on this under equalities legislation?

Sean Humber: Yes. For the last decade, we have regularly brought claims under the Disability Discrimination Act and, more recently, under the Equality Act in relation to unlawful treatment of clients and the failure to make reasonable adjustments in relation to disability needs. Age discrimination is relatively new.

Q41 Jeremy Corbyn: Have the cases you have taken, for example, resulted in any kind of systemic change by the Prison Service?

Sean Humber: There have been a number of cases. One exposed a failure of prisons at a higher level—by the Prison Service—to look at the needs of disabled prisoners and produced a policy in relation to that, which accepted, I think for the first time, that not all prisons could address the needs of all disabled prisoners and there was a need for prisoners to be allocated elsewhere. I have to say that sometimes, regrettably, there is a feeling that you are solving the problems on a case-by-case basis. Your clients' needs are subsequently addressed, which is the primary purpose of bringing these legal proceedings—it is not about money but about getting their needs addressed—but I have to say that I am less convinced that that led to a change in the attitude of the prison or of the Prison Service generally.

Helen Boothman: I endorse Mr Humber's view. Even with Prison Service order 2855, on disabilities, you find that prisons are not conforming to that. A classic example—bearing in mind the length of time that a lot of prisoners are now in their cells—is hard chairs. Older prisoners with back problems or who need lumbar support are sitting on old-school refectory wooden chairs; I cannot see any examples here. That really goes against any form of disability recommendation in terms of lumbar support and everything else. That is a very small example, but it can be taken further. You were at Albany yesterday. I wonder how many of you talked about the slopping out that still happens. For an older, more mature man with bladder problems, prostate problems or whatever, one questions why that has not been addressed even now, although it has been aired and reported on for some time.

Q42 Chair: The old lags' slopping-out procedure is not what they do. Integral sanitation is provided by portable facilities, isn't it?

Helen Boothman: It is in some cases. In other places, it is by electronic means. If it is in the middle of the night, you can ring your bell, but sometimes there is a time delay. If an older prisoner has bladder problems, obviously there are accidents.

Q43 Jeremy Corbyn: Do you have any assessment of the effect of the legal aid changes on the ability to pursue equality cases?

Sean Humber: I certainly do. They are likely to have a chilling effect on prisoners' ability to enforce their rights.

Q44 Jeremy Corbyn: Were all the cases you have taken legally aided?

Sean Humber: Yes, they were nearly all legally aided.

Q45 Jeremy Corbyn: As far as you are aware, would the same be true of other firms?

Sean Humber: It is predominantly legally aided work. The problem will be this. These are currently just proposals—they have gone out to consultation at the moment—but it seems to be proposed that legal advice for some treatment and care issues will be withdrawn. Whatever one's views of prisoners, they are a legally vulnerable section of society where there are clearly problems. We are talking not about *Daily Mail* problems of "I have not got Sky Sports in my cell" but about people who have not had a shower for a year, are not able to use the toilet because they do not have a booster seat, are not able to work because

no simple adaptations are being made or cannot get their meals because they cannot physically walk to the servery or cannot walk back with a meal in one hand. We are talking about serious problems. Report after report by the regulatory authorities and eminent NGOs say that there is a problem. The issue is how those prisoners will be able to have the legal advice and assistance they will need—which, after all, is not to obtain compensation but to get those rights enforced. It is a desperate thing, unless your starting point is that they are prisoners and therefore do not have these rights. If they do have these rights, it is illusory if they cannot enforce them. I have to say that I despair.

Chair: I think we get the point.

Jeremy Corbyn: We have got your desperation.

Q46 Mike Weatherley: My question is on the same point and is addressed to Ms Boothman. As Mr Humber was just saying, some people consider prison as a punishment or as rehabilitation; you can have those two things in there. You made the comment earlier that it is disconcerting to have people running around outside your cell, but a lot of my constituents say, "Well, they are in prison." I take the point absolutely that we do not want to increase someone's suffering and to inflict some sort of torture on a person, if a seat is really giving them extra problems, but where do you draw the line between what would be more comfortable—quite frankly, most people would say they are in prison and should put up with running around outside their cells—and serious additional care that they need and are not getting?

Helen Boothman: For me, it is about the individual and how you would want them to be treated if it were your father, your brother or your son who was in prison. The physical needs are part of the duty of care that a prison needs to support. Whether that is the adapting of cells, making sure that they have access to showers or making sure that they can get to the library and all the facilities they need to get to, the prison must supply it. In terms of how far it goes, most older prisoners you talk to get three meals a day, are warm in the winter, by and large, and get access to fresh air. It is absolutely fair to say that some probably have a better life, because they also have social involvement, but you question some others who express absolute frustration about not being able to move in the system.

I go back to legal aid, although I know you have probably moved on from that. There is a classic example of an indeterminate sentence prisoner in his 80s—I am not just using this as an example—who has to be seen to be reducing his risk by doing offender programmes. He is not accepted on to those offender programmes because he has memory loss, and he has been stuck in the system for over four years. It does not seem right to me that we should treat anybody like that. I know that it is hard to draw a line between public opinion and what is right and proper, but I think it is about fairness and justice. That is what IMBs are all about.

Q47 Mr Llwyd: Mr Humber and Ms Boothman referred to the whole issue of fragmentation of health services throughout the prison estate. I know it is early days, but what do you think will be the impact of the changes to commissioning arrangements for health services that came into effect this month? Do you think that they will reduce fragmentation? The question is open to all three of you.

Helen Boothman: I think it is too early to say yet. The early signs are that at the moment they are just talking about a bigger picture and not talking about specific needs of specific groups of prisoners. Some fantastic best practice has been going on, but what are the guarantees that it will carry on in the future? Manchester prison seems to have excellent leads, follow-through on screenings and everything else. It is really following through on the NHS framework for older people. I hate to repeat this, but of course there are inconsistencies. In other places you do not have a lead and are not getting the regular screenings, so you are getting postcode prisons.

Dr Wahidin: The move is a move in the right direction, in that it will encourage innovative practices and, hopefully, bring together best practice that can be evidenced in the work of HMP Norwich, Leyhill, Frankland and Downview, which is the women's prison. Yet again there is the caveat that we need to have the political will. We need to have champions and to highlight the issues, problems and challenges that older offenders bring to a closed institution.

Sean Humber: I do not want to be more downbeat, as I agree with what the two previous speakers have said, but we need to look back at the last decade or so. In the very bad old days—and they were very bad old days—the Home Office was responsible for the Prison Service aspects of health care. That led to some kind of health care apartheid, if you like, where people said, "It is health care that is different from but equivalent to what those in the community receive under the national health service." Clearly, it was not equivalent.

It must be said—and the Committee should be aware—that nearly everybody welcomes the transfer of health care to the NHS. The problem was that it was transferred to the primary care trusts dotted up and down the country, which were responsible for the prisons in their area. It is fair to say that some did a good job but some did a less good job. It is not all about resources, but it is partly about resources. Some of them felt that they received something of a hospital pass with a very needy section of society but did not have the resources to deal with that.

There has been a change again, with primary care trusts being abolished. You have one type of procedure for those in the community and a slightly different one now for those in prison. There is a possible downside to that. The good thing when the primary care trusts were responsible for both was that it was very stark, if you like, what treatment those outside the prison walls and those inside the prison walls were getting. That may be slightly further away now that there are slightly different commissioning arrangements, but it is too early to tell. The good side is possibly that we will get slightly more strategic management of it, in the sense that not all primary care trusts did a good job.

Q48 Mr Llwyd: Mr Humber, in your firm's submission to the Committee, you argue that the criteria for early release do not sufficiently take into account the needs of elderly prisoners. In your experience, what proportion of older prisoners who seek early release are given it?

Sean Humber: I am afraid that I have not got the facts and figures at my fingertips. The first point to make is that many do not get the assistance to make that application in the first place. Many come to us having languished, we would say; they would have been able to make the application far earlier if they had not. The second point to make is that there is a very—

Q49 Mr Llwyd: Can I interrupt you there? I am not being awkward—I just want to know who you think should be there to assist in that process of identifying a potential early release candidate and assisting him or her to process the application.

Sean Humber: I do not necessarily think it should be solicitors or lawyers. There needs to be somebody in the prison who is able to look at those issues, particularly the health and disability issues, and how well they are being met. It is a relatively reactive process. It should not involve their needing to go through the hurdles and hoops of getting solicitors in the first place. This is not touting for work. All I was going to say is that it is a real problem before we even get to that question.

Mr Llwyd: I am sorry that I interrupted you when you were answering the question. Please carry on.

Sean Humber: That is fine. I do not have the facts and figures at my fingertips, I am afraid. What I would say is that the Prison Service takes quite a strict view, if you like, of the criteria for early release. Actually, if you look at the policy—what it could do—it is slightly broader, but it is treating it as applying to those who are terminally ill and within three months of death. That is unduly restrictive and goes beyond the Secretary of State's powers and the Prison Service policy. It needs to be broadened out, as the policy suggested it should, to those the Prison Service cannot adequately care for. The question should be asked, would they be better cared for in the community? In our experience, that is not being done.

Dr Wahidin: As far as I am aware—I am sorry that I do not have the figures to hand, but I was looking at them over the weekend—the numbers are really negligible. That raises the question of why the numbers are so negligible when we know that there are prisoners who are languishing in prisons. Why aren't we considering the use of early release and compassionate release earlier and sooner, as in other jurisdictions and other countries?

Helen Boothman: You asked who should be responsible. I want to flag up that in most prisons there is a disability liaison officer. Under "Fair and Sustainable"—this wonderful whole new world of budget cutting—that post looks like it will be part of the equalities officer post. There is a fear that, with budget cuts and restrictions, the responsibility and, probably, the role of championing of older prisoners to develop individual care plans could easily go.

Q50 Chair: I am sorry for interrupting, but one has to ask why there should be a particular impetus for early release. If the court has given a sentence to someone who has carried out a very serious offence or, maybe, many very serious offences, such that they have not yet served their offence or gone successfully through an IPP procedure to be released, unless the judgment is that the amount of resource necessary properly to look after that person in prison is not available and would be disproportionately difficult and expensive to provide, what is the public policy argument for releasing that person from prison?

Helen Boothman: Compassionate grounds, I would say, because we are a compassionate society. If a prisoner who may have some time left to serve is not given the choice about where he wants to die, to be near his family and in surroundings that might be more suitable than a prison environment, I question the role of society in that.

Q51 Mr Llwyd: Could I move on to the Government's proposed approach to reform of the provision of social care—in other words, to devolve it to local authorities? Do you think this will improve matters? Given the situation local authorities appear to be in currently, will they step up to the plate and deliver as is hoped?

Helen Boothman: Social care is not mentioned at all with IMBs up and down the country. Only one IMB report just recently, on Frankland, mentioned social work even being visible in the prison. A classic quote from people at Dartmoor is, "Social care is being done by wing staff." I think we are at a place where it can only be improved, but I have questions and concerns about more co-commissioning. The first panel of witnesses raised the issue of responsibility and accountability. We are seeing that it is harder for the governor to have overall responsibility and accountability with so many third-party contractors on his site and delivering. If we have central commissioning, it must be really clear who is accountable for what and who is responsible for negotiating between the various bodies, because the bit that sometimes falls down the middle is the multi-agency reviewing of an individual case. Without the disability liaison officer, who will be responsible for co-ordinating all the various agencies and bodies around this prisoner? I am not clear about where that would fall.

Q52 Chair: Is it not preferable to a situation in which nobody accepts responsibility to provide personal care—that is really what we are talking about—for a prisoner who, basically, cannot function without it?

Dr Wahidin: I reiterate the points that the previous speaker just made, with the caveat, yet again, that there has to be the political will and drive to implement the legislation in order for it to work. It is a move in the right direction, and the Prison Service has a duty of care to provide all prisoners with adequate provision to assist with daily living.

Q53 Nick de Bois: I have two questions for Mr Humber. You made a very detailed submission; thank you for that. Clearly, you have a commercial interest

and a growing business. Can you let the Committee know what size of business legal claims from prisoners now are?
Sean Humber: I am afraid that I do not have the facts and figures. I can tell you about my practice, which consists of me and two other lawyers—

Q54 Nick de Bois: So we do not have a percentage figure, but it has grown.
Sean Humber: Yes, it is fair to say that.

Q55 Nick de Bois: You were kind enough to describe many of the common problems faced by the firm's older prisoners—for example, failure adequately to assess their health problems when they first arrive, failure to contact the community GP and obtain medical records, and delays and practical difficulties in seeing a nurse or a GP. Have you actually taken legal action on behalf of prisoners over those issues?
Sean Humber: Yes, they have been components of cases we have brought.
Nick de Bois: You have brought cases on that.
Sean Humber: They have been components of cases that we have brought on a multitude of issues.

Q56 Nick de Bois: You might understand some of my constituents' frustration—particularly if the cases were funded by legal aid—as these are problems that we face outside prison as well. I wonder whether you could put some context into that. If you are prepared to let the Committee know the size of the business, that would be helpful.
Sean Humber: Of course.

Q57 Gareth Johnson: Could I ask Dr Wahidin to build on some of the comments that Mr Humber made earlier in relation to disability issues specifically with older prisoners? I understand that you have stated that, generally speaking, prisons do not comply with the Disability Discrimination Act 2005. What instances do you have of that being the case? What evidence have you seen of anything being done to challenge that?
Dr Wahidin: I am drawing on some recent research from about a year ago for a prison in the north of England in the women's estate. There was a failure to provide adequate facilities for disabled female prisoners in this particular prison, so much so that a prisoner was unable to work. There was only one cell that had disabled facilities such as an accessible shower, an accessible toilet and a wide enough door to enable the wheelchair to pass through. At times, she was unable to move because there was no buddy system in place or prison officer able to wheel her from one part of the prison to another. With an influx of prisoners, a number of disabled prisoners had entered this particular prison. She ended up having to share her bathroom facilities with other prisoners because of the lack of provision at this particular prison, which therefore failed to comply with the Disability Discrimination Act and the Equality Act. It also brings us within the remit of article 8 of the European convention on human rights.

Q58 Gareth Johnson: Do you accept that in a prison establishment, by its very nature, there will be additional difficulties in catering for people with disabilities, compared with general society?
Dr Wahidin: Obviously the environment is a factor, but we have information that details the person's age, mobility and health and social care needs. Within that, we should be allocating prisoners to appropriate facilities to cater for their particular needs in order to fulfil the mission statement—the vision—that the Prison Service upholds.

Q59 Gareth Johnson: You said you would like to see prisoners allocated to where there are facilities and so on. In addition to that, is there anything that you feel we should be doing in the prison establishment that is not happening at the moment? Do you feel that there are things that are not being done at the moment that could reasonably be done for prisoners with disabilities?
Dr Wahidin: One is to make sure that the prisoners are allocated to an appropriate prison to cater for their needs.
Helen Boothman: The national strategy that was spoken about earlier is very lacking with regard to location. Wandsworth had to relocate all of its VPU recently, and many went to Brixton. Of course, Brixton did not have any ground-floor cells that were appropriate for those with mobility problems. Another example—it will be fascinating to hear your response after Monday—is Dartmoor being converted to a 100% VP prison. Dartmoor is one of the least accessible prisons in the prison estate, and one of the hardest to adapt for mobility problems. It has spiral staircases, great big, thick walls and very narrow cell doors. One wonders what the logic is behind adapting that to a VP prison that, by its very nature, will have older prisoners. That is where the lack of the national picture and the strategic view seems very apparent.
Sean Humber: There seems to me to be a lack of rigorous assessment of disability needs when the prisoner gets to prison. On reception, there is a questionnaire they can fill in that talks in one-word terms about whether they have disabilities. There is often a health care assessment a few days later that looks at health care issues, hopefully in more detail. However, often there does not seem to be joined-up thinking about how it will impact on what you can and cannot do if you have reduced mobility. Will you be able to get to the library or to visits? Will you be able to use the gym? Will you be doing this, that or the other? There does not seem to be follow-through from the initial one-word assessment and the health care assessment about how that impacts on a day-to-day basis.

Q60 Gareth Johnson: What is frustrating is that there is at least a perception that victims of crime in my constituency, because of disabilities that they have, cannot get to the library, cannot get the necessary health care and do not have the gold standard, if you like, that they need. Would you not agree that there is at least a perception that we can put all the emphasis in one direction, which leaves victims

of crime feeling that we may have our priorities wrong?

Sean Humber: I do not see it as an either/or issue. It seems to me that this is not really gold-plating. As I said, often these are cases of people not being able to shower for a year or whatever. You say either that the state has responsibility for, and a duty of care towards, those individuals and they should have these fairly basic standards or that it does not. To go back to my earlier answer, either they are entitled to that protection under the law or they are not.

I accept that there is a public perception issue. To a certain extent, that is unfair and is brought about by misrepresentation of a small minority of cases. There is a real problem of a lot of disabled and elderly prisoners—the "old and quiet" issue—from whom you never hear a peep. Solicitors never hear a peep from them. They want to keep their heads down, are scared in the prison environment, do not want to kick up a fuss and are grateful for ad hoc assistance, to the degree that they get it, from other prisoners and the kindness shown by individual officers. Often that is where they are, and they are too scared to move from there.

Q61 Gareth Johnson: Please do not misunderstand me. I am not saying that that duty of care should in any way be lacking. I fully appreciate that the punishment of prison is the incarceration and that humiliation should not be added on top of that. We want to rehabilitate people so that they come back with a good view of humanity, not a bad view. However, I come back to this problem that, if society, Government, the prison establishment or other establishments are putting the emphasis on ensuring that there is better quality for those in custody and more access to things people that on the outside do not always have access to, there is a sense that there is an imbalance that needs to be corrected. Would you not agree that there is at least that perception, if not the reality?

Sean Humber: I accept that there is that perception, but you need to look at why there is that perception. I think that sometimes it comes from the misreporting of certain cases.

Q62 Chair: Can I move on to the issue of resettlement? It is related, in a way, because much of the emphasis of the prison system is on trying to equip people for living a useful, constructive life when they are eventually released. This group of prisoners tends to be categorised as a group who are unlikely to be released until they are even older—at a very advanced age—so resettlement is not a priority. In that respect, they fare less well than other prisoners, as the inspectorate has pointed out more than once. Do you see any signs of improvement on resettlement?

Helen Boothman: There are little gems of good practice, but that is usually where third-party agencies such as RECOOP and Age UK have been involved, either through the day clubs or by helping people with pension planning, will writing and so on. Given the budgetary situation, I cannot see that it will be improved in terms of thinking about a release plan and helping a prisoner who has lost his home or will be living on his own to learn to cook, to wash and to manage his personal hygiene. That will take an awful lot of individual resource that I am not sure will be available. Given the very nature of the crimes committed by a lot of older prisoners, housing is inevitably a major problem, as sex offenders are—

Q63 Chair: Because of the public security and protection issues.

Helen Boothman: There is that. Very often, local authorities and private housing agencies also have blanket rules that they will not accept sex offenders, whether they are low-risk or high-risk sex offenders. Until that changes and there is more education, it will be a major problem when it comes to locating these more mature men out in the community. It is an issue because, as we know, all the people in prison, bar a handful, will be returned to the community. It therefore does need managing. As we all get older, problems tend to be more exaggerated. Last week, I was having a conversation with an 84-year-old prisoner who just burst into tears because he had had to sell his house since coming into prison, was being released in October and had no idea what was going to happen to him when he was released. That is a classic example of the lack of communication to individuals. If you were in the community, you would go and find the information. There are not the places to go to seek that information and the reassurance that an individual needs. I think that is a worry.

Dr Wahidin: The role of third-sector involvement, working in partnership with certain prisons in the prison estate such as Norwich, Frankland and Styal, has improved the provision, but again it is ad hoc. It is very much dependent on the resettlement officer, the PO and the SO. However, this particular cohort brings their own particular challenges that prison officers and resettlement officers find it difficult to deal with. The prime example is the one that you have given of an older male offender who is about to be released. If a hostel or local authority refuses to take him on board, what do you do? How do you cater for the needs of older offenders in that category?

Sean Humber: I agree. I will not repeat everything that the two other speakers have said, but I will make two points. One goes back to the issue of disabled prisoners being able to do the offending behaviour courses and adaptations being made to enable them to do that. While there are undoubtedly examples of good practice, there are many cases where they just do not do the course. The second point is very specific but is worth mentioning to the Committee. There is a particular problem with hostels and how compliant they are with disability requirements. Often, prisoners are not able to be released to hostels because the hostels are not able to take them.

Q64 Chair: One problem we have not mentioned, which was referred to us yesterday, is the problem of prisoners who are in denial about historic sex offences. Some of them may actually be innocent, but there are significant numbers who cannot complete courses because, even if they agree to take part in them, before they get very far they get engaged in the kind of discussion in which, effectively, they are

refusing to co-operate. Do you have any thoughts about how that should be dealt with?

Helen Boothman: Looking at sex offenders and the treatment programmes generally, deniers or those in denial of their offence or conviction will not be accepted on to the current range of programmes available within the custodial setting. There was talk that NOMS was going to produce a new SOTP to which deniers could have access, which would help them to reduce their risk and progress through the system. In the annual report on the prison I monitor, we raised that last year. It was going to come out during the year that has just been, but there is still no sign of it. I do not know whether that is down to budgetary cuts and the segmentation project, which means that all low-risk prisoners, even the sex offenders, will not have any offender treatment programmes. That comes back to the public perception of rehabilitation within the prison setting.

Chair: Thank you very much. We are very grateful for your help this morning.

Tuesday 14 May 2013

Members present:

Sir Alan Beith (Chair)

Steve Brine	Mr Elfyn Llwyd
Jeremy Corbyn	Seema Malhotra
Nick de Bois	Andy McDonald
Gareth Johnson	Graham Stringer

Examination of Witnesses

Witnesses: **Dr Seena Fazel**, Royal College of Psychiatrists, **Dr Iain Brew**, Royal College of General Practitioners, and **Professor Jennifer Shaw**, Offender Health Research Network, gave evidence.

Chair: I apologise for the delay in starting this part of the session. We had some other business we had to complete. Can I warmly welcome Dr Seena Fazel from the Royal College of Psychiatrists, Dr Iain Brew from the Royal College of General Practitioners and Professor Jennifer Shaw of the Offender Health Research Network? We are really grateful to have your help in the work that we are doing on older prisoners, which has taken us to a number of prisons, so we have been looking for ourselves at the situation. We want to look particularly now at their healthcare needs, and I am going ask Steve Brine to open the questions.

Q65 Steve Brine: Thank you very much, Chair, and thank you very much for coming. Good morning. Starting with the RCGP, could I just ask you, in your view and your experiences, how do you think the healthcare needs of older prisoners differ from their counterparts in the community and from younger prisoners?
Dr Brew: It is well recognised that older prisoners are biologically older than their counterparts outside, often because of social exclusion that has been long-standing and poor engagement with healthcare services when they are in the open community.

Q66 Chair: That is measurable and measured, is it?
Dr Brew: It is certainly anecdotal. Whether it has been measured I would not like to say, but it is certainly observable. I have personal experience of seeing this in my practice, which goes back over 12 years. Comorbidity is a big problem. People will tend to have several health problems and these may well be compounded by poor self-care. They may well have had self-care issues outside as well. My practice is in Leeds. We have several older homeless chaps who come in on a regular basis, so they are not really able to access healthcare outside and their self-care is poor because of their homelessness. These things all compound each other.

Q67 Chair: Would anyone like to add to that?
Dr Fazel: Yes, if I may just add something. It has been measured, so people have done surveys where they have compared chronic illnesses—physical illnesses and also mental illnesses. But, if you take physical illnesses, people have compared the rates of physical illness reported by older prisoners and also documented in their medical records and compared them with people of similar age and similar gender who live in the community. It is a little bit difficult to make the comparison exactly like for like, but, as well as people can do, it is probably about double the rate of physical health problems. For instance, if you take any chronic illness, a survey done in the UK—it is a bit old now; it is about 10 years old—found that about 85% of men over the age of 60 in prison reported a chronic health problem. If you look at surveys of other people in the community of a similar age, you tend to find 20%, 30%, 40%; so you do find some disparity in physical health problems. The same thing has been found in the US, where there are two or three quite good and large surveys of physical health problems.
Professor Shaw: I don't know if you wanted to go into the mental health as well.

Q68 Steve Brine: We will come on to that. I am mostly interested in what the prominent healthcare issues are conditions-wise, but if you have any thoughts on that, please chip in.
Professor Shaw: I have nothing else to add.

Q69 Steve Brine: Just going back to Dr Brew, you talked about comparables. We were on the Isle of Wight recently and the number of older prisoners is set to increase, partly because of advances in technology, which bring people to prison many years after the offence. There is quite a lot in the news at the moment about this. They could have been leading perfectly normal, healthy lifestyles on the outside, and then they come on to the inside. They don't suddenly then develop chronic conditions, so does that challenge what you said at first?
Dr Brew: Yes, there are two populations. There is the prison population who have been in and out over many decades and have aged through the criminal justice system, as it were, and then, as you quite rightly say, there are people who have been living relatively normal lives and come in later. Both groups exist; there is no doubt about that, and I see them on a daily basis. Increasingly, over the last decade or so, you are absolutely right—there are people who are coming to justice many years after their offences, but they also bring in a number of health problems in the same way. It is important to bear in mind the two types of older prisoner.

Q70 Steve Brine: What do they bring in? Could you just give us some examples?

Dr Brew: You may well have patients who are type 2 diabetics, who have heart disease and lung disease from smoking and so on. The comorbidities all come together and make it a challenge to look after people. This is where social care gaps come in. People are not able to care for themselves because of their conditions.

Steve Brine: We will definitely come on to that. I think we will move on, Chair, because you have a lot to get through.

Q71 Jeremy Corbyn: Could we turn now to the issue of mental illness? Evidence seems to suggest that the rate of mental illness among older prisoners is much higher than the equivalent cohort in the community. I would be grateful if you have any information on that. Secondly, are you confident that there are enough people working in the Prison Service who have any knowledge or experience of issues such as dementia and psychological disorders among older people, and are there issues there that need to be addressed?

Dr Brew: There are probably people who are better able to comment than I, but I would say, yes, there does need to be more provision. We have had, for the last 12 years or so, mental health inreach teams, which are the secondary care provision, coming into prisons. Increasingly now we are getting primary care mental health nurses coming in, but their expertise may well be in substance misuse and learning difficulties. Getting someone who has extensive experience of dementia can be quite challenging. We diagnose dementia not infrequently, but I am sure there are cases that are going under our radar because we are not specialists in that field. I am sure that you are right that there could be more provision.

Dr Fazel: In terms of rates of mental illness, the particular mental illness that differs is depression. Rates of depression in older prisoners are probably about three times higher than the equivalent age and gender equivalent person in the community. Compared with younger prisoners, it is also higher. That would be the one illness that stands out. There have been a number of studies, including a recent study, that has confirmed that. In terms of other mental illnesses, the rates are not dissimilar to younger prisoners, apart from dementia, where it is not certain, but it may be around 1% of older people in prison who have dementia. That is not different from an aged-matched community group.

So it depends partly on your comparison. Compared with people in the general population of similar age, they seem to have higher rates of depression; compared with younger prisoners, you also have higher rates of depression and obviously higher rates of dementia.

Q72 Jeremy Corbyn: In your experience do older prisoners, when they come in, suffer from the same levels of mental illness conditions in the general sense and does it get progressively worse in prison, or are they already in a pretty difficult state before they arrive? Have you any way of assessing that?

Professor Shaw: We did a study not specifically on older prisoners looking at what happens to mental health as you go through prison. What we found, interestingly, was that all types of mental health problems improved in prison, but this was all ages and not just older prisoners. As far as I know, there has not been a similar study in older prisoners to see what happens to their mental health over time, but that was a general study that we did. There were significant improvements in people's mental health in prison. We put that down to the fact that people often live quite chaotic lives in the community, but when they come into prison they have some stability and healthcare—perhaps for the first time—and, therefore, their mental health improved, but I cannot comment on the older people.

Q73 Jeremy Corbyn: The three of us went on a visit to Dartmoor two weeks ago and, clearly, some of the prisoners were totally traumatised at being brought in at all. They had been brought in for offences committed 30 years ago in some cases and they had recently arrived. What I observed—I don't know if my colleagues would agree—was that there was a sense of community among the older prisoners that possibly would not have existed in their lives outside prison in the same way. I thought that there were interesting contradictions almost in their behaviour.

Professor Shaw: That is quite variable. Certain prisons have older prisoner wings. We have one in the area where I work in the NHS in Wymott prison and there, definitely, you get a sense of community. But in our recent study we did it in several prisons, some with few older prisoners. That was a very different picture.

Q74 Nick de Bois: Professor Shaw, I note that you were the chief investigator for a National Institute for Health Research-funded study that investigated the health and social care needs of other male adults in prisons. Were you able to give us an assessment or draw a conclusion as to what extent prisoners receive an equivalent level of healthcare to that which they would expect in the community? Are you able to do that?

Professor Shaw: Yes. The study that we did looked at various aspects. The aim of the study was to develop a screening instrument for health and social care needs for older prisoners, but, as part of the study, we did a national survey of health and social care provision in all prisons that had older prisoners. The most striking finding was that staff reported that there was a virtual non-existent provision of social care and that was the main and significant problem, because, while most people had older prisoner leads, there was a problem with health and social care policy that only about half of the prisons had one, and they said the particular problem there was the social care bit of that. That was the most striking thing from the national survey. In terms of equivalence, we looked at needs and provision of care, and we found, similar to Dr Fazel's study, that there were high rates of depression. What was striking with that was that only one in five of the people who had depression were on antidepressants and only one in six were in contact with the services.

Q75 Nick de Bois: How does that compare—presumably unfavourably—with what you would find in the community?
Professor Shaw: Yes; it is worse.
Dr Fazel: It is a little bit worse. The study that I found is that one in four people in the community who are older people in the community with depression are—
Chair: Could you speak up a little because the acoustics in this room are not very good?
Dr Fazel: Yes. We did a similar study where we looked at how many people with depression in prison were getting antidepressants, and it was one in five. At the time that we did it, we had a look at the equivalent study in the community and it was one in four. So it is a little bit worse in prison, but there still is a huge unmet need. Three out of four prisoners with depression are not getting adequate treatment.

Q76 Nick de Bois: In the study, did you look at how consistent older prisoners' access to healthcare and prescriptions was, and did you examine or make any recommendations as to how this could be improved? Is that an area that you looked at?
Professor Shaw: Yes. We did not look at consistency between prisons. That was not something we looked at, but we did make recommendations. The tool that we developed, which is delivered by prison officers, was designed in conjunction with older prisoners, and we felt that would be useful to try and detect some of these mental health and social care problems.

Q77 Nick de Bois: That was a tool you used to make an analysis in a prison.
Professor Shaw: This is what we developed as part of the study, and we now have further funding to do a randomised control trial—
Nick de Bois: To roll it out.
Professor Shaw: To see if it works.

Q78 Nick de Bois: Dr Brew, we saw a quite extraordinary difference. We had an older persons unit at HMP Parc, which was basically saying it couldn't be faulted; it was fantastic. Elsewhere, it was far from it. Have you drawn conclusions from your work in Leeds? Are you able to draw any comparisons as to how consistent across prisons older prisoners' access to healthcare is—and prescriptions particularly?
Dr Brew: The variability around the country is not that surprising when you take into account the different types of prison. HMP Leeds, for instance, is a large category B local prison, so it is for short sentence and remand prisoners, with a churn of 6,000 people a year, with a roll of 1,200. In other words, each space is churned five times. We have a considerable number of older prisoners who are a bit stuck at Leeds, because some of the other training prisons that they would be going to are full with long-sentence people already. In a very busy category B local, you are going to have the primary health need being substance misuse and alcohol. Most of the energy is directed towards the treatment of those issues. We have developed a team of nurses who deal with long-term conditions—lifelong conditions. Probably the majority of our healthcare contact with older prisoners comes through that group, and they will involve me, as the GP, in directing the care of these people. That has been a big change in allowing us to deliver decent care that probably is equivalent. But you are right—there will be a huge variation around the country.

Q79 Nick de Bois: Can I just press you on one point because that sounds very encouraging? Do you, therefore, have more effective liaison between the prison healthcare staff that you have described working well, and the nursing staff particularly, and the healthcare staff in the community—you sound like you were very local-based, so they may have come from local practices if they had healthcare before—when they come out of prison? Do you think you are getting joined-up healthcare through their journey before, through and after prison?
Dr Brew: We are doing our best to achieve that, but when we ask for information from local GPs, because the two computer spines are not linked, we often get a single sheet of paper, which is the whole medical record, even for someone who has complex needs.

Q80 Nick de Bois: If you need to follow up, are you getting frustrated? Let's face it—that happens now, sadly, whether you are in prison or not. Do you find that co-operation is less attentive because you are working in a prison with older prisoner self-care needs, or is it pretty much what you find everywhere?
Dr Brew: It is getting better and better since 2004, when prison healthcare commissioning was passed to the NHS. There is a lot more collaboration now than ever there used to be, and it is improving. This is not just a Leeds thing; this is national. The Secure Environments Group at the RCGP often discusses this and the push towards getting the NHS IT systems to merge. The resistance is from NOMS, primarily because of security and some very high-profile people. We wouldn't want to know where they are.
Nick de Bois: That is interesting.
Professor Shaw: Also, can I just say a little about discharge? It is a massive problem. Again, we did a study, not in older prisoners but in all prisoners, and found that of people who had been under the care of mental health inreach in prison, which is the equivalent of secondary mental healthcare in the community, we had 100-odd of these people who are under inreach, and on discharge only four got plugged in to services in the community. These were people with severe mental health problems. So, out of 100, it was only four. I think it is a massive issue.

Q81 Mr Llwyd: Professor Shaw, the memorandum that you sent about unmet needs is very interesting. Are you aware of the evidence that we received from Leigh Day, a firm of lawyers that specialises in dealing with complaints made my prisoners? I will just very briefly refer to one or two points they picked up on. They are: failure to assess health problems on arrival at prison; failure to contact the community GP and get the notes; delays in seeing nurses or the GP while in prison; and, finally, transfers to other prisons when they then miss the connection with their consultant who is supposed to be dealing with them and thereby they fall down to the bottom of the list in

another place. What do you think is the reason for this sort of disconnect? Is it because there is a stand-off between the prison authorities and the NHS, or is it a problem of thoughtlessness? What is the reason for this?

Professor Shaw: To answer that in this way, our study looked at needs of prisoners, and, again, it agrees with several of the points made by your previous expert. One of the main unmet needs—we use a standard measure of needs—was for information received by the prisoners. They felt there was a massive problem. They were not informed about what was going to happen to them about transfers, moves around and things like that. That, to them, was the biggest problem, which kind of agrees with what you said. The other ones were psychological issues and activities. In terms of what that is about, I don't think there is a purposeful disconnect between prison staff and the NHS. The point of the prison is for security mainly and that is the overarching goal of the Prison Service. Therefore, at times it is very frustrating working in prisons, because you are treating somebody and they get moved. I don't think it is a purposeful thing; it is just dealing with security issues or having to move people around for accommodation issues.

We do try to hold people. If we are treating them we can put on a medical hold, as it is called. That is quite often effective at getting the prison to keep somebody who is going through treatment—but not always so. It is a definite area that we need to work on because it causes enormous problems for prisoners. Particularly if they are quite troublesome prisoners, they tend to get moved all the time, which is probably the worst thing that could happen, because in a way you want them to have some stability, so you can get to the problem. We are constantly, on a local level, trying to work with our own prisons on this, to get them to keep hold of people, particularly if they are going through a period of treatment. Anecdotally, we are getting there a bit, but it needs much further attention.

Q82 Mr Llwyd: We visited Dartmoor a few weeks ago, as you have heard. I have to say that the staff there were very caring and committed to the work that they were doing, but, in general, would you say that there needs to be more raising of awareness among staff of this particular issue and perhaps some additional training?

Professor Shaw: Absolutely. That is what the problem is. It is raising awareness of how damaging it can be if somebody is undergoing treatment, has a relationship with a particular inreach team in my field of mental health, and then they get moved and they get moved again. It is very difficult to keep that engagement. We are always trying to raise awareness of that on a local level, but nationally it would be very useful.

Q83 Mr Llwyd: Do you find, in your experience, that staff are perhaps reluctant to prescribe medication or to take prisoners to hospital because of possible security issues and so on?

Professor Shaw: I suppose I can only speak anecdotally from the five prisons in my patch. Actually, I don't think that is the case. We have been looking at this in our services recently. The numbers of people going out to outside services, both for outpatient appointments and emergencies, is actually quite high. There doesn't seem to be any blockage in taking people out. It is very expensive and we are looking at more cost-efficient ways of doing that. I don't think that seems to be a problem, but I can only speak for our five prisons on that one.

Q84 Gareth Johnson: I have a question for all of you about the lack of a national strategy when it comes to dealing with the healthcare of older prisoners. It seems at the moment that it is left very much to local prisons and equalities legislation to look after this. Do you think, taking into account the fact that we have new commissioning arrangements, that there should now be a national strategy dedicated to looking after the health needs of older prisoners? Who wants to go first?

Dr Brew: Yes.

Gareth Johnson: Yes; thank you. Why is that?

Dr Brew: It is unclear how the new commissioning arrangements are going to play out just at the moment being so early on, but there is an opportunity with a lower number of commissioners around the country to get more consistency around England in prison healthcare. We know that the older prisoner population is rising; it has doubled in the last decade. We project that it is going to go further, as far as I understand, and this is a very complex group. So, yes, some national guidance would be very much appreciated. Clare Gerada, the chair of the RCGP, commented yesterday—this isn't just about prisons; this is about older people in general—that, if properly resourced, better joined-up working between GPs, secondary care and social care can deliver better health and well-being for our elderly patients. That definitely speaks to prison healthcare. So national guidance and a way of delivering reliable social care in the prison setting would be excellent, yes.

Dr Fazel: The Royal College of Psychiatrists would support a national strategy. Researchers have been calling for this for over 10 years now, so it is something that people have highlighted previously. Part of it also comes out of the fact that some prisons will inevitably have fewer older people in them and so they will not have the opportunity to develop expertise. Therefore, having a national strategy will enable minimum standards to be set; even things like thresholds for when you treat or admit someone or move them to a hospital could be quite helpful. We see that in the rest of medicine. If you have basic guidelines, that tends to generally improve the quality of treatment. But at the same time that needs to be audited. So, after a year or two of the new national strategy, there needs to be a cold, hard look at to what extent it has been implemented and whether it has actually improved outcomes.

Q85 Chair: Do we take it for granted that there would automatically be a national strategy because it is now the NHS Commissioning Board, not local primary care trusts and not the clinical commissioning groups who will be commissioning prisoner health

services? Are you assuming that it just follows that they will have to have a policy because it is a national body anyway?

Professor Shaw: I don't assume that. It should definitely follow, yes. It makes sense to; I agree.

Dr Brew: With NHS England, I know the commissioning board are going to be informed by clinical reference groups, and clinical reference groups will hopefully have this on their agenda. If they don't, they should.

Q86 Steve Brine: Briefly picking up on the Chair's point, everybody is aware, of course, that prisoner healthcare is commissioned through NHS England. Very interestingly, I was talking to NHS England Wessex yesterday, in the area that I represent. We have quite a lot of prisons in Hampshire, in the Wessex area, and prison healthcare services are being commissioned by the Thames Valley structure across the entire Thames Valley/Wessex region. It is quite a big regional reach. Therefore, does that not give you confidence that there is a more overarching picture instead of just local commissioner groups looking at this?

Dr Brew: I said earlier that we are reducing the number of commissioners from around 80 to more like 10.

Q87 Chair: Hang on a minute. Aren't you reducing the commissioners from 80 to one in respect of prison healthcare?

Dr Brew: Yes. There is one overarching commissioner, which is NHS England, but my understanding is that that is then going to be devolved to local teams, and 10 local teams are going to be involved in commissioning prison healthcare. I would agree with you that reducing the number of commissioners can only improve consistency, but the clinical reference groups will have to have older prisoners' health needs on the radar for that to work.

Q88 Steve Brine: To be clear, the Royal College of GPs did not support the Health and Social Care Act reforms, which this is now ushering in.

Dr Brew: I am here on behalf of the Secure Environments Group of the RCGP, which is the national hub for prison GPs. I am not well placed to comment on what the RCGP may or may not have said about healthcare reforms.

Q89 Chair: On a related point, we found it quite shocking that nobody seemed to be taking responsibility for the social care of prisoners who could not perform basic functions because of their medical condition. This was not something that prison officers were trained to do or allocated time to do. There was no consistency and very little actual positive experience, so far as we could see, of a system to make that provision. Is that impression mistaken or correct?

Professor Shaw: No, that is correct. From the national survey, it was the most striking finding. Local social services will not provide services for the prison in their area. There is all this argument about whether it should be provided by social services in the place where the person comes from or where the prison is, and nobody ends up doing it, which is very problematic.

Q90 Andy McDonald: Can I ask you about end-of-life care? We have evidence from the Prisons and Probations Ombudsman that he found in an investigation into end-of-life care that the majority of prisoners with foreseeable terminal illnesses—54% of them—died in hospital, a quarter died in prison and 15% died in a hospice. Of those that died in prison, 73% died in a healthcare centre or in their cell. There have been improvements, but it was also found that a third of prisoners didn't have a palliative care plan in place. I just wondered, in your experience, what your view was as to whether it is possible to provide effective palliative care in prison.

Dr Brew: I was lucky enough to spend five years working in hospital as an oncologist—a cancer specialist—so I came into prison medicine with quite a good understanding of palliative care. I have been involved in the palliative care of probably 15 or 20 prisoners over my 12 years working in prisons. My experience is that we have been able to deliver very good care with the involvement of Macmillan and using their Gold Standards Framework previously.

In 2011, the National End of Life Care Pathway was introduced with a special prison version, and that is being rolled out increasingly around the country. But it is interesting that you speak about the Prisons and Probation Ombudsman. One of my other roles is to do clinical reviews of cases, and I have done several where palliative care has not been very well managed. It is to be hoped that the National End of Life Care Pathway prisons version is going to lead to improvement. People are much more aware of palliative care, but it is a specialist field and the expertise is not necessarily in place. You have to bear in mind that an awful lot of prison nurses have not come from primary care in the community; they have come from hospital jobs previously, and they may not be very familiar with caring for patients in the community setting. So that is a matter of training. As I say, I hope that the National End of Life Care Pathway will lead to improvements around the patch, but there is certainly space for improvement.

Q91 Andy McDonald: Moving on from that, do you support an increase in the use of early release on compassionate grounds, because we have heard from witnesses that that really ought to be expanded in the case of terminally ill patients? Does anyone support that in principle?

Dr Brew: Again, yes, absolutely. It is part of my care planning for anyone who has a terminal disease to look at the possibility of either compassionate release or release on temporary licence. Governors are understandably very risk-averse when making their decisions about releasing patients, and it has to be recognised that with some older prisoners, particularly those who have been guilty of sexual offences, the risk goes on until they are completely immobile. While, yes, I am in favour of making the application, it is understandable that quite often those are rejected.

Q92 Andy McDonald: Do you think the balance is right between the security and compassionate grounds? Do we have that about right?
Dr Brew: My personal experience would say that governors are a little too risk-averse.

Chair: Thank you very much. We are very grateful to the three of you for your very helpful evidence this morning. Now we have some further witnesses. Many thanks.

Examination of Witnesses

Witnesses: **Paul Grainge**, Lead Capacity Building Consultant, RECOOP, **Dr Stuart Ware**, Director, Restore Support Network, and **Gill Walker**, Chair of the Older People in Prison Forum, gave evidence.

Chair: Welcome, Ms Walker, Chair of the Older People in Prison Forum of Age UK, Mr Grainge, Lead Capacity Building Consultant for the charity RECOOP, and Mr Ware, Director of the Restore Support Network. We are very grateful to you for coming in today and giving evidence in this inquiry. You have been listening to the proceedings so far. I am going to ask Mr Brine to open the questions.

Q93 Steve Brine: Thank you very much, Chair, and welcome. This is for any of you to start; by all means fight it out among yourselves. In your experiences, what do you think are the main priorities we should have for supporting older prisoners, both inside prison and then on their release?
Gill Walker: The priority has already been alluded to, to some extent, with regard to the need for a policy or a national strategy, with policies and a framework that work, so that initially, when prisoners come into prison, there is a full assessment for both healthcare needs and social care needs and this is also reviewed. Once that is in place across the board—there isn't really the consistency within the Prison Service—this would certainly help. The need for social care is evident, with a range of activities and social care generally, right through to resettlement and rehabilitation through the gate. So there is a whole range.

Q94 Steve Brine: That would be a very good moment to ask Dr Ware to come in, because through the gate is what you are partly all about, isn't it?
Dr Ware: Yes. I support the concept of a national strategy, from our experience, especially being involved with the Isle of Wight project, because at the lower level you have the professions that are getting on with their job, but they work within their boxes. What we have found, and we have found in other places, is that, if senior management and commissioners are involved and there is a national strategy, there is a top down where it is led and there are instructions on how to deliver their boxed services that involve liaison between the other disciplines. One of the biggest failures I find is that some disciplines do not connect with another discipline. So you have healthcare and local social services, and you have the Prison Service even within a prison not communicating because they have their own remit. There is a need for a national strategy to drive it down from the top, from Government Departments. I like "Transforming Rehabilitation", where it mentions about Government Departments working together and then driving it down through the commissioners into the local services. If that is missing, then you are going to continue to have problems.

Q95 Steve Brine: That would be through NHS England and its regional directors.
Dr Ware: Yes, but making sure that the connections with the new police commissioners, crime and prevention commissioners, and local authorities all link up. If they don't link up, they are going to be protecting their own budgets and their own services, and I am afraid that older offenders will end up falling between the gaps.
Paul Grainge: In addition to the healthcare and social care problems that have already been mentioned, the meaningful activity for the older cohort is very important, certainly for us. We are finding that in the majority of prisons the regimes are geared up around education and vocational training to get the younger majority into employment, but for the older cohort there seems to be very little meaningful activity for them to keep up the maintenance of their practical, social and personal skills. We have seen in a number of prisons, limitations in what is being delivered, and restricted to carpet bowls or dominoes, at the worst extent. In some prisons, there are some great services being provided, and I know you have seen some of the good work that is going in Dartmoor. Providing an environment where they can maintain some of those social skills and keep themselves mentally stimulated is an integral part before they get ready for that resettlement stage and preparation for release, so that they can carry that forward and ensure that they maintain that independence perhaps to live in the local community when they move out, successfully.

Q96 Steve Brine: You work in partnership with Dr Ware's organisation, do you not?
Paul Grainge: Yes, we work very closely with it.

Q97 Steve Brine: Do you share Dr Ware's enthusiasm or optimism for the "Transforming Rehabilitation" proposals that are winding their way through Government at the moment?
Paul Grainge: I do. What I have read and the fact that we are going to be picking up and supporting those who are serving less than 12 months is a great move. I am conscious that the older cohort has not been defined as a specific group, but I am also conscious that there are very small numbers of older prisoners being released. But the level of crisis they have is huge, so that would be an area of concern. The identification of the resettlement of prisoners three months before—

Q98 Steve Brine: Do we know the number of older prisoners, as in over 60 by our category, or over 70 by the category that some prisons define them as, which is slightly awkward, who are released inside 12-month sentences?
Paul Grainge: I don't have that information, I am afraid.

Q99 Steve Brine: It would be interesting, if you did come across that information, to feed that into us.
Paul Grainge: It would be really helpful, particularly if we are looking at the new single rehabilitation activity and attendance centre orders, to look at increasing the work and specific services around the older cohort, because, if we could perhaps divert some of those at an earlier stage so that accommodation isn't problematic and social isolation[1], then that would be a huge step and an area of interest.
Gill Walker: Obviously, most of the initiatives look at older offenders from the age of 60, but there are quite a number from the age of 50—another 3,000 or so—and they may be approaching 60. I don't know where they are within the ages of 50 to 59, but clearly, from what we have heard previously, many older offenders present themselves being much older than you would find in the community. The 3,000 who are there currently are a significant number in the 50 to 59 age group. I just mention it in passing.

Q100 Steve Brine: That is a very good point. Do you think we have it right with our 60 as the older—
Gill Walker: From an Age UK point of view, we would focus on 50-plus for those reasons—very much so.

Q101 Andy McDonald: It seems to me the consensus is that 50-plus is the age range. We did actually see an 83-year-old, who was a new arrival, who was very sprightly. Could I ask Dr Ware about the common assessment framework, because we visited the Isle of Wight as part of the inquiry? I am just interested to know from your research into the project what lessons you think might be learned to correct some of the failings in social care that some witnesses have told us about.
Dr Ware: When we commenced the evaluation, we found out that in the relatively local, small Isle of Wight Council there were over 100 separate assessments of needs carried out by different agencies. This led to a duplication of assessments. If someone had multiple care needs, the prison would call in a professional from a caring agency to carry out that assessment. There was a multiplication of care assessments with the agencies repeating similar care questions to the same older prisoner. We found there was marked failure of inter-agency communication and an unwillingness to share information. It was only when this was raised with the IOW steering group that involved senior managers that action was taken to ensure that services were integrated and delivered by local practitioners, such as prison healthcare and social services integrated care assessments. My guess would be that you could repeat this exercise in other prisons around the country and find a failure to produce a common care assessment.
We found there was a willingness by prison staff to support older prisoners. They had a caring remit. You always get the odd prison officer who might take the view, "My job is just control and security," but, overall, there was a good, caring ethos, especially when it came to older prisoners who were together in a wing or a unit where they were together.
When I went to Whatton prison, I found there was a very good older prisoners' unit in which prison officers volunteer to work in that unit. There was a caring ethos for those with disabilities or care needs. One of the outcomes of this research is that where specific assessed care needs of older people with disabilities are assessed, their care plans may require them to receive specific services that their current prison placement cannot meet. You cannot expect a prison like Dartmoor, with very small entrances to their cells, to be able to provide wheelchair access throughout the prison. We found similar problems in the main Albany block in HMP Isle of Wight. Therefore, special units were created which enabled those with wheelchair disabilities to gain access to the facilities which also made it easier for thee staff to manage.
We also found that the Isle of Wight prison not only carried out healthcare assessments in Reception for new intakes, but when they identified an older person with care needs and was aged over 50, that a second needs assessment was made during the Induction stage. Then every six months, they were then given a Wellman care assessment. This followed the Department of Health guidance 'Pathway to Care for Older Offenders: a toolkit for good practice' (2007). Our evaluation report identified that where there was intervention as a result of the integrated care needs assessment within the prison, it reduced the costs to the NHS later on when they came to be released. It was very cost-effective.
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Q102 Andy McDonald: That is very helpful, but we still have this dilemma as to where this provision is coming from—from the local authority or within prisons. If you get the local authorities to take responsibility, the prisons might step aside. Do you think that an obligation upon the local authority to provide care would improve the lot of older prisoners? Would we have better outcomes?
Dr Ware: Yes, it would improve it. I have no doubts about it. It would probably need legislation, as was recommended, but it depends on whether it is the local authority where the prison is based for a small council or a small local authority like the Isle of Wight, with the largest prison population in the country, or whether it would be the original local authority where the person was resident when they were sentenced, where they would most like to return unless there was a restriction on their licence.

[1] Note by witness: Although I did say social isolation here the word I was actually trying to say was institutionalisation [...]. I was trying to describe some of the aggravating factors that could be removed if an older offender was managed using a community disposal. Social isolation was not the right phase at all.

Q103 Chair: Is there not a difference here between where you might think the costs should be dealt with and where you think the provision should be dealt with, because it seems inherently absurd to imagine Cumbria and Mid Wales and somewhere else all trying to organise social care in a prison in London?
Dr Ware: I agree. There is something to be said for almost the funding following the patient to meet the care needs, which was one of the original aims of CAF (Common Assessment Framework). The concept was that the funding might follow that individual with assessed care needs.

Q104 Chair: But the provision should surely be made by one authority per prison. It could be commissioned by a larger body. Should it fall into the national health commissioning structure that has now been created? We are looking around to see—because nobody seems to be effectively responsible at the moment—who should be.
Dr Ware: If you want my honest opinion, it should come within the national health service provision because it is the healthcare professions—the NHS professions—that pick it up more than the local authority, who lose track of the person who may have been a resident 20 to 30 years previously before they were sentenced. That is my own view.

Q105 Jeremy Corbyn: Can I move on to the question of staffing and staff training? As you may be aware, we visited a couple of prisons who had older prisoners. In the Isle of Wight they suggested that there ought to be specific training for caring for older prisoners rather than taking, as you simply describe it, volunteers to work in that section. In your experience, what kind of training does take place?
Dr Ware: There was an initiative funded by the Department of Health, where Nacro produced a workbook (A Resource Pack for Working with Older Prisoners, published in 2009) to help prison and even probation staff to raise awareness of older prisoners' needs. I have been around asking, Where is it? It has disappeared. There was a little bit of follow up training when the pack was produced, but there is no training. Prison officers' roles have changed so rapidly, and one that had done the training may well have moved on. It could have been a disability liaison officer, equality officer or whatever they were called. They change the officers and maybe the training manual has disappeared with the changes. It may be used to keep a door open or something like that, but to the best of my knowledge it is not used as a resource pack.

Q106 Jeremy Corbyn: It must be a big manual.
Dr Ware: It is two. One of my original concerns was that it was going to get lost. I said this to Nacro, "They're going to lose it." There's no provision for this training. If there was an external body, I thought Nacro or some other body might be doing the training. What is needed is some consistent training for prison officers who are changing roles. The same would apply to prison healthcare—and I would also say the new Probation Service.

Q107 Jeremy Corbyn: Is there any record kept of the training that officers have had so that, if officer X starts off in, say, Pentonville, moves on to somewhere else and ends up in Dartmoor, moving around the country as some do, they have a specific specialty in older people that the service would be aware of, or is it not as scientific as that?
Dr Ware: I would agree with you that it is not scientific. They don't do it because their role is control and security. That is quite correct, and they have a caring role within that. But that can change from one to another, as they move from one prison to another. I would like to see a professional recognition that there are prison officers who are trained, just as some years ago there were prison officers who were trained as nurses. That was a plus. There is no consistent training for prison officers. With the growing need of older prisoners and the care need that is going to increase, I would say there is a need.

Q108 Jeremy Corbyn: Does it happen in any other specialty in the service?
Chair: Ms Walker wants to come in on this point.
Gill Walker: I just want to comment on the Nacro documents—the Nacro files—because they are extremely good. They were rolled out via Nacro on training for those who came from prisons. Sometimes, it was a governor who would come on this particular training. They got the packs. They then rolled them out to every prison in the country, as I understand it. They were extremely good because one was about the ageing process generally, so there was a general awareness and information about what it means to grow older, and all of us are. The other one was really about the sort of activities that would help enable well-being within a prison setting. They are extremely good documents. If these had been taken on board at the time in a very meaningful way, with the training and awareness raising for all prison officers, this would have done quite a lot at that stage. Those documents are available. They are not that old and they are still relevant.

Q109 Jeremy Corbyn: Just to come back on one point, do you have any knowledge of any other special training, apart from the former nurses in the Prison Service, where there is a kind of qualification recognition that goes through their careers?
Paul Grainge: I am not aware of any, but within the capacity building project that I am working on, which is funded by the Women and Equalities Group within NOMS, one of the objectives we have is to develop some training around the ageing process, health problems, linking behaviours to the underlying issues, and some resettlement needs. That is something that we are working on, and we are certainly developing a lot of resources around the signs and symptoms of those types of ailments that are likely to present for this group, which are going to be on a website that is accessible to all prisoners, and also I hope will go on to the Virtual Campus intranet system as well. That is work in progress, but it is still early stages at the moment.

Q110 Graham Stringer: What are the particular requirements for preparing older prisoners for resettlement while they are still in prison, and are these requirements being met?

Paul Grainge: Shall I start?

Graham Stringer: I didn't think it was such a difficult question.

Paul Grainge: In our experience, the preparation for the older guys and women is limited, and we are finding that there is not a great deal at all and it is a real problem. We are certainly aware that there are older prisoners who are going out without photographic ID, bank accounts, accommodation, and not having registered with a doctor or a dentist. Certainly, if they have been incarcerated for long periods of time, I am aware that the electronic age and just the fast pace of living in the community is really difficult. My colleagues in the direct services that we are delivering are seeing that there are prisoners coming back in, and one of the aggravating factors of them self-sabotaging some of the licence conditions is that they have explained that they just can't even buy food in a shop. They have gone into a shop where they have not had the confidence to speak to a cashier and they have not understood how the self-serve aisles have worked or how to use them. The fact that they have not even been able to buy food was almost the straw that broke the camel's back. That was one of the reasons why they have self-sabotaged.

Resettlement for the older prisoners is a huge area. We are looking at the moment to try and develop a 16-week countdown where we can look at work with other older prisoners and train them in resources to help get a timeline in place, so that we can try and support those who are getting ready, and we can give them some photo ID—the basics really. We can help them get their national insurance number, if they do not have it, and find out where their doctor is, help them get registered, just so that the basics are there in place, because at the moment it is very sporadic between prisons as to what they are getting, I am afraid.

Dr Ware: I find, unfortunately, that a lot of resettlement officer roles have been changed because of cutbacks. Some of them are no longer resettlement officers. They are now on duty on the wings. I will give you an example. In the Isle of Wight prison, what was called a passport to care and resettlement was first developed by the prison orderly and resettlement officer in 2010. Now this 'passport to care' programme no longer exists. There is only one resettlement officer now responsible for the whole resettlement programme and I am she just cannot develop the resettlement programme on her own. The prison Orderly who helped to produce the 'passport to care' has been released for the past two years and I have kept in touch with him. He is now going to be working with me and with Restore in Devon. He is picking up that 'passport to care' and we are going to be working with RECOOP to develop this in the South West peninsula, as well as in Hampshire, with the Isle of Wight and the Hampshire Probation Service.

The problem, to answer your question, concerns through the gate resettlement is a very weak spot; there is no responsibility or very little responsibility for assisting an older prisoner prepare for their release while they are inside. It is expected that everything is done for them. Once they go through the gate, it is expected they have to do everything themselves. For example, they have to report to the probation officer that same day; they may have to travel by public transport from one end of the country to the next and be there on time, otherwise they have broken their licence. There is no through-the-gate resettlement. That is the biggest missing gap, and I am afraid unless we can fill this gap in resettlement there will be more recalls and reoffending. A possibility is that the private and voluntary sector can fill this gap, as identified in the Ministry of Justice 'Transforming Rehabilitation: a strategy for reform' (May 2013)

Q111 Graham Stringer: Is there any difference between the experience and the basic support between men and women in these situations?

Dr Ware: My own experience of working with a number of women ex-offenders who are part of our support group is that I wonder how on earth some have ended up in prison. Some of them are very short-sentenced, and a number of these have come from abusive relationships or have drink problems and separated from their families. Many of them have families but they have lost their connections. In some ways, there is more difficulty getting them back into their local community because their family connections are broken, especially if they are expected to go back to abusive relationships.

Overall, I find there are a number of common factors between both sexes of the ageing prison population. They are—lack of accommodation, lack of knowledge of the local situation because some of them may have been in prison for a while, and no ID. Some are being released with no identification and no connection with GPs. I picked that up the last time. There is a very poor connection between the releasing prison and the local GP, unless they go to a probation hostel. There are some specific needs of women, but there are some common factors for men and women.

Q112 Mr Llwyd: One of the very big problems in this area is when prisoners are released with no fixed abode. I think I am right in saying that it is probably more acute in terms of the fallout for the individual if a person is of advancing years, because the statistics show that older prisoners, by and large, are sentenced to between four years and life, so they have spent a lot of time being institutionalised and it is an extra shock for them when they come out without anywhere to live. I was with the group in Dartmoor and I spoke with an elderly gentleman there, who said that he had eight days to go and he was at that stage NFA, so it is very worrying. The point that you make, Mr Grainge, about a countdown period is extremely important, to be honest. Those are general points. I don't know if you are aware, but there is legislation in Wales to prevent the release to NFA. Should our friends on this side of the border adopt that, do you think?

Dr Ware: Yes. There are two women who were due for release from Eastwood Park, and return to south

Wales, and they were in a group of older women I was recently visiting. The women who were due for release in England were rather envious of the support the other two were going to get when they were released. One of the women in England has been in touch with me, and she is homeless; she is still NFA. The two from south Wales have been housed.

Q113 Mr Llwyd: At least we get some things right. What are the most significant issues faced by older prisoners in general vis-à-vis resettlement?
Gill Walker: Perhaps reiterating what has been said, it is the preparation that is not there in advance and walking people through what it would mean, so that they have the information. Age UK, for example, has substantial information and advice for people generally and could be tailored for older prisoners in resettlement and moving towards release. If that was enabled within the prison, it would be helpful as one part—one very small part. There is also a need for volunteers perhaps, if they can be recruited, to be involved earlier and then to walk through the gate. Everything is very separate and compartmentalised, and it all needs to come together for the benefit of each and every prisoner.

Q114 Mr Llwyd: I remember, when I started off in practice as a lawyer, the rule was that a person being released from prison would be met by a probation officer on the way out. That is going back a few years, but we seem to have fallen into bad practice since then, and this no fixed abode is obviously asking for trouble. The other point I wanted to ask you about is this, and I understand the complexities of it. There are, of course, other problems with regard to resettling sex offenders in the community, are there not?
Dr Ware: Yes. There are restrictions on where they can go and there are exclusion zones. I suppose this applies to the majority are sex offenders that I am supporting at the moment. The one good thing—if I can say it is a good thing—is that, with some exceptions, they have to go to an approved probation hostel. That gives us time to work with the probation staff and negotiate with the offender manager about where they can be located and in helping them to find accommodation. In one sense, they get the support because, with some exceptions, they have to go to an approved hostel premises. That is something that works well with sex offenders and violent offenders. There is a problem with other older offenders, especially short-sentenced. As soon as they are released and walk through the prison gate they are on their own. My answer on sex offenders is that the system is working well.

Q115 Chair: That is very helpful; thank you very much. Does anyone have something to add on that particular point?
Paul Grainge: I was just going to add this about one of the problems that we experience. I have talked about the preparation, the 16-week countdown, but also, when they are coming out, where they are because of their age—they are old, frail and vulnerable—we are finding that sometimes there is no referral to the social services. They are going out to no fixed abode, but some of them are also going out having had their mobility support—their frames or their wheelchairs—taken away from them at the prison gates. Once they get off the bus, it is as far as they can manage to walk. They are stuck. It is so important that we make those links with social services and the prison and then help at least to put the basics in place. It is just the basic human needs, and then the support can be built around that.

Q116 Jeremy Corbyn: Thank you very much for coming today and giving us the evidence. Is there anything written or published on the idea of training prison officers, which I raised with you in questions, that we might consider for our report?
Paul Grainge: Not that I have seen, I am afraid. I am not sure at all what training there is for this at all.
Dr Ware: The thought I did have following our previous discussion on prison officer training. There could be a way forward in which the Prison Service College at Newbold Revel might include older prisoners in their officer training programme. Funding for this should be built into the programme.
Chair: Mr Ware, Mr Grainge, Ms Walker, thank you very much indeed. We are really grateful for your evidence. That concludes our proceedings this morning.

Wednesday 5 June 2013

Members present:

Sir Alan Beith (Chair)

Jeremy Corbyn	Seema Malhotra
Mr Elfyn Llwyd	Andy McDonald

Examination of Witnesses

Witnesses: **Jeremy Wright MP**, Minister for Prisons and Rehabilitation, **Michael Spurr**, Chief Executive, National Offender Management Service, and **Bruce Calderwood**, Director, Mental Health, Disability and Equality, Department of Health, gave evidence.

Q117 Chair: Welcome, Minister, Mr Spurr and Dr Calderwood. We have another Minister who is an ex-member of the Committee giving evidence in front of us. I am sorry we are a little depleted this morning; it is not our normal meeting time.

The Committee has been actively looking at the issue of older prisoners and has visited a number of prisons that have quite large numbers of older prisoners. They are the fastest growing sector of the prison population by far. Do you have an estimate of the additional cost of an average older prisoner?

Jeremy Wright: The answer to that is no. That is because older prisoners are not a homogeneous group, as you will appreciate. They have a variety of different needs and, therefore, a variety of different costs attach to providing for those needs. Unless Michael can tell me differently, we do not have an estimate of what it will cost per older prisoner. You are right that they are the fastest growing group. That is from a fairly low base, of course. I think we have a little over 3,000 prisoners over the age of 60 in the estate at the moment.

What we have to think about, as you say, is not just how we manage those who are already in the estate but the increasing numbers that we will see coming through the estate. That is about regime and also the physical nature of the estate—whether or not we need to think, as I believe we do, about the design of new prisons in the context of accepting older prisoners into them and to talk about regime and how we manage the regime to assist those who are of working age, certainly, but also those who are older than that. There are a number of things we have to think about for the future as well as managing the existing issue.

Chair: We will explore some of these things in a bit more detail. In fact, I invite Seema Malhotra to do so.

Q118 Seema Malhotra: Thank you very much, Sir Alan. There are different arguments for and against a national strategy, and the focus placed on the needs of older prisoners can vary a lot between prisons. Our witnesses have consistently argued in favour of a national strategy to tackle the problem of this inconsistent provision. There is an acceptance that older people do not have identical needs, but the strategy could identify at least a way of providing a set of minimum standards. How would you justify your and the Government's current position on this?

Jeremy Wright: My reluctance on this is partly based on a fear that, if you have too many priorities, you end up with no priorities at all. Similarly, if you have too many national strategies, none of them mean very much. I am not sure that the national strategy approach is the right one here, mostly because, as I said a moment or so ago, it seems to me very clear that older prisoners are not one uniform group about whom we can have a sensible set of criteria.

We need to be clear throughout the prison estate—and I think this applies to prisoners of every age group—that our system is flexible enough to deal with the individual needs of each individual prisoner. There is huge variation. Depending partly on how you categorise an older prisoner—some categorisations say over 50 and some say over 60—you can imagine that, even if you are talking about the over-60s, there is huge variation in the nature of those individuals, and therefore finding something that is consistent and equally applicable to say about all offenders and prisoners who are over that age would be very difficult.

I think we can do more to make sure that guidance is available—and it is available as a result of the collaborations we have had with various voluntary sector bodies and others, some of whom you may have talked to—to ensure that those who work within prisons understand the particular challenges that older prisoners may present to them, whether those are physical or mental. Those elements of guidance should be properly available, in clear form and everyone should be able to get hold of them, so that they can understand the sorts of things they need to be looking out for.

Michael may want to say something about that, but that is probably where we need to be looking, rather than to construct a national strategy, which I think would be limited in its utility, because the things it could include would either have to be so general as to be meaningless, or it would have to be a very long document trying to address all the potential problems that this fairly wide age group, with a fairly wide range of problems, might present to us. Michael, do you want to say something on the guidance point?

Michael Spurr: Yes, on the guidance point and on strategy. We do have minimum standards for treatment of prisoners. Our standards require individual assessment of need and appropriate provision for that need. That includes people with needs who are older in prison. In the work we have been doing with our health partners, and now through NHS England, there is a clear and improved screening for prisoners coming through in health needs, which is a particular issue for older prisoners. We have, in my view, clear

minimum standards and a strategy that links to need rather than simply saying that we are going to have a cut-off at a particular age.

Because of the differentiation with older prisoners—57%-plus of older prisoners, for example, are sex offenders who will have particular needs—the argument about, "Why don't you have older prisoner units?" for me does not stand up on the basis that you have to look at the need and the offence. That does not mean to say that in some prisons we would not put older prisoners together—indeed, in a lot of prisons we do exactly that—but you would look at the needs for the individuals. It would not be right, necessarily, to put people with different offences together just because they happen to be of a particular age if that did not work in addressing their particular needs as individuals.

But I agree with the Minister. We have worked very hard with external groups like Nacro; there is the work we have been doing with RECOOP—Resettlement and Care for Older ex-Offenders and Prisoners—and the work we are doing with Age UK. We have the Nacro good practice guidance, which is on our intranet. I had understood the Committee was saying that that had been lost in prisons and I was taken a bit aback because it is on our intranet; it is difficult for me to see how it would have been lost.

But I do think we can do more about making sure that we share the good practice. The RECOOP piece of work that we are doing in the south-west is designed to build capability for how we address the needs of older prisoners. They are producing website guidance as well, which we will share across all prisons to get a greater and better standard of understanding across the estate.

Q119 Seema Malhotra: I understand about guidance and some of those projects, but there was some talk about key outcomes in your submission that you talked about that you would be looking to explore and identify for older prisoners. I understand there is a lot of variation, but there is some commonality and part of the challenge is to get into that. What are the key outcomes referred to? Are there any examples of what is being looked at and monitored in any way beyond the guidance that has not focused on outcomes?

Michael Spurr: For me, the priority has been the whole issue about social care, both in prisons and for offenders when they leave prison and go back into the community. That has been a gap and that was the most important thing, it seemed to me, to come out of the last inspectorate report in 2008. The work that has been going on with the Department of Health in taking forward the Health and Social Care Bill, which was—

Chair: We are going to look at that specifically later.

Michael Spurr: That is important. On the resettlement outcomes, which are the specific issues that were raised about whether these are marginally worse for older prisoners, one of the key issues for me is the portability of the social care plans that, in future, will be developed in prisons and then will be utilised when they are going into the community. That has been the key priority for me in terms of how we can improve outcomes for older prisoners.

There are marginally different outcomes. It is broadly 84% going into accommodation compared to 88%, but you do not want poorer outcomes at all for older prisoners. The issue is about the social care that is required and how that is delivered.

Jeremy Wright: In terms of the specific outcomes that are measured, there is a set of outcomes that are measured while someone is still in custody and then a set of outcomes that are measured in terms of resettlement.

In terms of resettlement, there are two particular things that we could highlight: one is accommodation, as Michael has already made reference to, and the other is employment. Of course, when you are looking at older people, whether they are offenders or not, employment outcomes might be different. In so far as accommodation is concerned, there are particular challenges around finding accommodation for older ex-prisoners, partly because there are a large number of them who have served longer sentences, so that in itself makes it more difficult. Landlords are more reluctant to take on people who have left prison. There are particular challenges around resettlement from that point of view.

Inside prison there are a number of things that we would look at, one of which is how many prisoners get to the higher levels of the incentives and earned privileges scheme. I think I am right in that case that older prisoners do pretty well; we do see more older prisoners getting to the top of the incentives and earned privileges scheme at the moment than younger prisoners on average.

There are a number of different things that we measure, but, as Michael says, we are really interested in plugging the obvious gaps that there are here. For older prisoners, there are going to be huge challenges around the physical design of the estate—mobility problems will influence that, access to health care, and access to social care. In relation to those two things, which I know we are going to come on to, there are some significant and very positive changes being made.

Q120 Andy McDonald: On accommodation of older prisoners, one of the key questions seems to be whether they should be mainstream, as it were, or integrated. When we went on our visits, the consensus was that older prisoners benefited from being in a mixed age range, subject of course to having their specific needs addressed. We visited Dartmoor and were very impressed by the regime there, without any shadow of a doubt, but the building had its limitations and we found on occasions wheelchairs could not get through the doors. So there were issues there.

To what extent are age and infirmity taken into account when deciding where to detain prisoners? The Prison Officers Association claimed that there was "institutionalised overcrowding," which made taking into account factors such as age and infirmity "virtually impossible". How do you respond to that?

Jeremy Wright: It is fair to say that age and infirmity are certainly considered in deciding whether or not a prisoner is in the right prison. Most of our prisons will have the capacity to accommodate people with mobility problems, but, as you rightly say, some of

the older prisons are more challenging than some of the newer ones. That is part of the reason and logic behind a strategy on estates that transfers us from an older Victorian estate, in many cases, towards a much more modern estate, where we can design in some features that will allow this to be managed better.

In relation to your earlier point, you are absolutely right that there is not consistency here in terms of what prisoners themselves want. Some prisoners who are older want to be accommodated with other older prisoners; some want exactly the opposite and do not want that at all. There is not a consistency of approach here. If we were to be institutional about it, from our point of view, in the management of the prison system, it is quite a good thing to have a mix of ages, because what you can find is that older prisoners have a positive and calming influence on younger prisoners. It may be very much in our interests to see a mix of ages—

Q121 Andy McDonald:—and support the younger prisoners.

Jeremy Wright: Absolutely right. There is already some very good peer-to-peer mentoring that is going on, a lot of good work on reading, for example, with prisoners teaching other prisoners to read through Toe by Toe and other very worthwhile schemes. The more of that that we want to see, the more likely it is that a mix of ages will support that kind of work.

From our perspective there are huge advantages in having a mix, but in the end we want to accommodate the needs of each individual prisoner, whatever they may be. It goes back to an earlier point that it is very difficult, and probably not desirable, to say "Older prisoners need x," or "Older prisoners must be accommodated in such a way," because it is not true of every older prisoner and each individual prisoner must be treated in the way that is most suitable for them.

Q122 Andy McDonald: Do you agree with the Chief Inspector of Prisons, who says that there are some prisons in the estate where older prisoners simply should not be held?

Jeremy Wright: There are certainly some prisons where the physical restrictions are such that it is very difficult to manage a prisoner with significant mobility difficulties, for example. Michael will, I am sure, want to say something about the capacity that we have.

Michael Spurr: The difficulty probably most often becomes apparent in local prisons—Victorian-style local prisons are not at all designed for wheelchair or disabled access—and where people are in those prisons because they have been remanded by the court or have been initially sentenced by the court and need to be held relatively close to the court in order to go back. That gives us some challenges.

Our responsibility is to make adaptation to be able to accommodate people in those establishments. We have not always done that as well as we should. I talked to Nick Hardwick about examples he has found where that has not been done. In those instances it is right to move older prisoners on to better accommodation that is more suited to their needs once we are through the court process. That is where the biggest challenge is for us. In most cases we have a range of accommodation that we can manage quite reasonably—not with older prisoners so much, but with prisoners who have a particular disability, mobility problem or physical issue around climbing stairs and so on that can make it more difficult.

Q123 Jeremy Corbyn: On that point about accommodation—and I think my views will be shared by my colleagues—when we visited Dartmoor, we met a lot of older prisoners, and the atmosphere was much less tense and aggressive than it can often be in male prisons. It seemed to me that there was, in some levels, quite good interaction between the older and younger prisoners, and the older prisoners, in a way, became a steadying influence on the atmosphere there. While I accept the need for a degree of separation, there can be a degree of mentoring that can be quite helpful.

Jeremy Wright: I could not agree more. That entirely chimes with my answer to Mr McDonald. There is huge advantage to us. As we want to see more mentoring and peer-to-peer support, all of those things are hugely valuable in the operation of a prison; the more of that we can have, the better. There is good evidence—and it is evidence that we have all seen as we have gone round prisons—of exactly that kind of interaction happening.

There will be some older prisoners, as I say, who either prefer to associate with other older prisoners or, almost by default, do so because they have committed the sort of offence that older prisoners predominantly have committed and therefore will find themselves together, especially if they are vulnerable prisoners. There is no reason for us to proceed down the line of institutionally considering that the right way to deal with older prisoners is to put them all together, and we may find that there are disadvantages to us in the way in which prisons are run and operated if we were to do that. So I agree with you.

Q124 Mr Llwyd: I share my colleagues' views. I also accompanied my colleagues on the visit to Dartmoor and there is a very proactive regime there, but they appear to be completely stymied by the architecture, to be frank. To be fair, Mr Spurr, the problem is not simply local prisons. Dartmoor is not a local prison; people come from all over the UK to Dartmoor. It is a broader and bigger problem than that, is it not?

Michael Spurr: I said I thought that our main difficulty was in local prisons where people have to be held by the courts. Dartmoor, yes, is an 1800s prison—an old prison—and has those disadvantages. But I also said that it is our responsibility to make appropriate adaptation to be able to accommodate older prisoners.

Would I like newer prisons that are designed for today's needs? Yes, of course I would—that would be great—but at the minute we are still using Dartmoor; we have adapted Dartmoor. I am glad you found the regime was good there, and the regime is, I would say, more important than the physical conditions, as long as you are able to adapt the physical conditions for people to be able to live reasonably.

Jeremy Wright: This goes to the heart of the argument that we had during the last period of prison closures. The argument was inevitably going to be partly about finances and whether or not it is cheaper to run a newer prison than an older prison, which of course it is, but it was also about the nature of the regime that you can properly operate within a newer prison.

Michael is absolutely right that the regime is more about the people and the systems than it is about the environment, but, frankly, the good regimes are run in many prisons despite the environment and not because of it. Anything we can do to move our estate from older buildings to new buildings we should do. That is why, as we keep the estate under review, we will continue to aspire to getting rid of some of the older accommodation, much as there is sentimental attachment to it in many of the communities where it is located. Despite that, it is obviously better for us to run a good prison regime in a new building than an old one.

Q125 Mr Llwyd: I appreciate that, but some of the prisoners told us—not from Dartmoor, by the way—"I'm not allowed to go out on exercise because there is a step out into the exercise yard," and others said, "The education block van can only be accessed via a multi-flight, outside fire escape. When I couldn't get up it, I was placed on punishment for 10 days for 'refusing to work'."

If you were a business, you would have been sued to kingdom come under the Disability Discrimination Act. It is high time that these things are addressed urgently, to be frank, because of what these people are being put through. I appreciate, Minister, that you are doing your best and I am sure you will do your best, but I am highlighting that it is an urgent problem that needs addressing.

Michael Spurr: If I could just be clear on that, if those things happened—and I am not saying they did not happen—that is completely unacceptable and should be addressed immediately. It is not acceptable at all to say that any prisoner cannot get access to outside exercise. It is a statutory requirement that we provide that. Therefore, if that occurred in that way and it was raised, it must be dealt with. There is the same issue about education. While it may not be possible, for example, in that case, for the individual to access education but they needed or must have the equivalent opportunity for education, we have arrangements for one-to-one provision or you can have provision on the wing. There are different provisions to be able to meet that.

There is a system whereby, if a prisoner feels he is being treated in that way, that is in breach of the Disability Discrimination Act—no question. If that is the case, they have a whole range of means of complaining about that, including through to the Prisons and Probation Ombudsman, who I am sure would find in their favour if that was the case, and we would be required to take action. I am not saying that did not occur—and things can go wrong in a system—but that should have been addressed.

Q126 Seema Malhotra: I was thinking about what mechanisms prisoners do have. To what extent are those mechanisms really used? Do you think you are hearing those stories? Are you getting that feedback?

Michael Spurr: The mechanisms are used. There is a formal requests and complaints procedure in prisons that leads eventually to an independent ombudsman, who gets a significant number of issues and complaints that they investigate each year.

Q127 Seema Malhotra: Do you believe you are hearing the extent of what is going on, or are you just getting a very small snapshot coming through that system?

Michael Spurr: You certainly hear the whole range of issues, and it depends on the type of prisoner as to how extensively they use the complaints system. Those in prison for a long time and older prisoners are much more likely to use the complaints system, as they tend to be people who are better educated and have seen more of life; they will use a complaints system much more than younger prisoners.

The people who use it least are children—which is why we have advocacy services in young offender establishments—and young adults. Also, there are the independent monitoring boards, which are really important in prisons. They provide that watchdog role from the local community and are very alive to these particular issues. It is quite proper that they are. They are on site every day, or most days, in most prisons. Then there is the independent inspection. There is a fair amount of information about where people are.

Internally, we also do our own surveys measuring quality of prison life, developed by the Cambridge Institute of Criminology, which look at the whole range of factors that are operating in regimes. We ensure that that is done in every prison at least every two years and in some more often if we are concerned about particular prisons. There are a lot of ways of getting an understanding.

I am not saying things do not go wrong in prisons—of course they go wrong; people don't get every decision right, and some prisoners are sometimes subject to things that they should not be—but we have processes to find and deal with them when they happen.

Jeremy Wright: It is worth adding on independent monitoring boards in particular that, when I visit prisons, I always see the independent monitoring board privately without the prison governor's staff being present and ask them how things are going. I have yet to find one that does not have a very good working relationship with the prison governor. If prisoners come to the IMB representatives, as the IMB representatives say they regularly do, with particular issues or complaints about the system, IMB representatives feel they are entirely able to raise those with the prison governor. That relationship appears to me to work very well.

You are right that there is inevitably a risk that prisoners will not necessarily raise with prison officers particular worries that they have, especially if they think that those are deep-rooted problems within the system. But it does seem to me, as far as I can tell, that the IMB system is a very good check, which people are prepared to use, and the IMB is then able

to transfer complaints on to the governors. That seems to be a very good safeguard to me.

Q128 Mr Llwyd: On a more general point, do prisons include what you might call "purposeful activity" by older prisoners as part of their equality monitoring?

Jeremy Wright: I will let Michael answer the question specifically on equality monitoring because I do not know the answer to that. There certainly is an expectation that within the definition of "purposeful activity" there should be no discrimination based on age. In other words, for example, if you are of retirement age, you will not be expected to work within prison. But it is important that we make other opportunities available to people, either to learn or to engage in other kinds of activity.

If we go back to the discussion we had a little time ago about mentoring and support for other prisoners, one of the changes that you will know I made to the incentives and earned privileges scheme is to ensure that, if you want to be on the enhanced level of the scheme, you have to do more than keep your nose clean and engage in your own rehabilitation; you also have to give something back to the prison more generally or to other prisoners.

We need to make sure that everything within prison is structured around giving people the opportunity to do something productive and positive. My understanding is that we will be very clear on the requirement for all prisoners to have access to some form of productive activity. It does not have to be work. If you are of retirement age, we would not require people to work, and there will be more opportunities, I hope—particularly for older prisoners who have, frankly, more to give very often on this—to engage as mentors, friends and listeners to other prisoners. I hope there will be more, not fewer, opportunities in the future. Michael might be able to help us on the specific equality point.

Michael Spurr: Every prison is required to monitor equality outcomes. That includes protected characteristics for disability and age. Yes, therefore, they can break down what is the access to particular activities by age. The focus predominantly in that area has been on race rather than age, to be quite frank, to ensure no disproportionality in that area. The biggest difficulty for us is disability rather than age and being able to identify the disability and potential adverse impact that might have on individuals. That is the reality of the situation we have, I think. It is more difficult in being able to identify the range of potential disabilities and then being able to monitor that in terms of activity.

Q129 Mr Llwyd: I have one final question, if I may. You will know that there has been some concern about the restraining of prisoners, particularly the older prisoners. The Prisons and Probation Ombudsman investigations into natural deaths in custody "too frequently identified inappropriate use of restraints on seriously ill prisoners being taken to hospital or hospice for treatment." Peter McParlin told the Committee that "Prison officers used to have discretion in these matters," but now, "Decisions on restraint come from management, and management is risk-averse…" Will you consider reviewing the policy or guidance on restraining seriously ill prisoners being taken to hospital or hospice for treatment?

Jeremy Wright: Yes. In terms of the policy position here—and I will let Michael add something from an operational perspective—we are in the right place, which is that every individual case of a transfer to hospital or a visit out of the prison for medical treatment must be risk-assessed on the basis of the individual circumstances. It would be quite wrong for any of us to say there must be a blanket policy on what type of restraint is applied for prisoners who leave the prison environment and go to a hospital. It will obviously depend on the individual prisoner, the nature of their offence, their illness and treatment. All those things are going to be relevant to each individual decision.

Would I be prepared to say, as the Minister responsible, that in every single case that judgment is reached in the right way? No—of course, I cannot say that. But I believe, from a policy point of view, it is quite right that the decisions taken on the level of restraint necessary must be based on a risk assessment because that is obviously the sensible way for us to proceed.

One of the key points of vulnerability for us is the period of transfer from a prison to a hospital. The public would expect us to take the necessary precautions to ensure that prisoners cannot get away from that environment or cause any harm while they are in it. Some form of restraint is sadly necessary. We need to have common sense. We need to apply plenty of common sense when we make those risk assessments, and we need to apply a degree of humanity too, because it is not appropriate that prisoners, for example, who are dying are shackled or restrained in a way that is not justified by a risk assessment. I would deprecate any example of that.

It is the right policy position to say that each individual case must be assessed on its merits and the risk assessment must be a robust and common-sense one, but it must recognise that not every prisoner who goes to hospital for treatment is completely incapable of escape or, indeed, incapable of causing harm in that environment. It is a balance to be struck in every case.

Q130 Chair: Who is supposed to do the risk assessment?

Michael Spurr: The risk assessment is done by a manager from the prison. That is appropriate because, if you give discretion to prison officers who are on an escort, they will face significant pressure, potentially, from the individual who is with them, the family and others that are around them. The potential to make a poor decision in those circumstances is significant. The aim is that there is a risk assessment done that takes account of the behaviour of the individual—for example, when they are on escort—but also all of the external security risk factors that need to take place. I agree with the Minister that the policy is not wrong. The policy says that we should take account of all those factors, including the risks for somebody who is seriously ill to be able to escape. Following the Prisons and Probation Ombudsman's report on

findings from natural deaths in custody, we have reinforced the importance of taking that seriously.
There is a balance and it is a difficult judgment. There was one escape from prison in the last 12 months from Pentonville. The person who escaped was over 60 years old. He managed to scale Pentonville's wall and get over. It does not follow that, because you are over 60, potentially you are not going to try and escape. This was a person who had been in custody for a long time. Similarly, when people go to hospital, knowing when somebody, tragically, is going to die is difficult. Some of the people who go out have committed very serious offences, and there is concern from the public and others, particularly if they happen to be sex offenders, in a local hospital and so on. Balancing that judgment is difficult and it is right that that is done objectively.

Q131 Mr Llwyd: It is interesting that, in your description of how the risk is evaluated, you do not refer at all to the views of the prison officers.
Michael Spurr: I am sorry. I said that—I did actually.

Q132 Mr Llwyd: You did not. I listened very carefully. You did not say anything about them.
Michael Spurr: I said they would take account of the behaviour at the time. If I did not make clear that the people who know what the behaviour is like are the prison officers, then that was my failing.
Mr Llwyd: I see; okay.
Jeremy Wright: It may be something we are about to come on to, but there is another dimension to this, and that is the judgment that has to be made in some cases about compassionate early release from custody. If you have a prisoner who is terminally ill, a judgment has to be made at some point as to whether or not—
Chair: We will come back to that.
Mr Llwyd: May I, through the Chair, by the way, apologise to the three of you? I have to leave before the end of the session.

Q133 Andy McDonald: Can I turn our attention to the issue of staff training? We have an old report from HMIP that found that no staff outside health care had received specific training in dealing with older prisoners. More recently, the Prison Reform Trust noted that the basic six weeks' training previously included an hour specifically targeted at older people; but from this year diversity training is being integrated, so there is no focused training on older people. Perhaps Dr Calderwood might make a comment, but I would ask you to consider whether it is reasonable to expect prison officers to deal with prisoners suffering from dementia without training.
Mr Calderwood: First, can I correct you? I am not a medical doctor, unfortunately; I am just an ordinary civil servant, so my title gives me more status than I deserve. From a health point of view, it is good that whoever is responsible for looking after, say, somebody with dementia has an understanding, for example, of what those needs are. Again, it is not a question of looking at what an older person's needs are but what the health needs are for the specific circumstances, such as the needs of somebody who has a physical or mental impairment or who is easily confused.
The crucial thing from our point of view is that the healthcare staff are properly qualified and able to provide adequate health care. In a sense, what the training requirements are of staff within prisons is not something that I am in a position to comment on.
Michael Spurr: I am happy to say a bit more if that would be helpful. In terms of general training, it is right that the whole issue about equality and managing people by their individual need is how we address that training with prison officers. An hour on older prisoners cannot possibly cover the whole range of things you might need to look after for an individual. Taking an hour out that was devoted to older prisoners and saying, "Throughout the whole course, one of the emphases is going to be about how you operate and manage people as individuals and where you access specialist help and care," which is what the focus is, is the wrong approach.
We have not done specific training for prison officers on older prisoners, but we have access through things like the Nacro guidance that is out there, that people can access, and we have healthcare staff in every establishment who have particular expertise.
We have put our emphasis on training with the Department of Health on mental health awareness. More than 17,000 staff have been through mental health awareness training, and that includes looking at a lot of the similar issues around potential dementia. There is a whole range of other mental illnesses that the prison officers can face in prisons. That training is not to get somebody to become a skilled mental health practitioner, because we cannot possibly hope that prison officers are going to be in that position, but it will identify the issues that might lead them to raise with specialists how the particular needs of individuals might be cared for.
Jeremy Wright: I should declare my interest. When I first came to Parliament, I set up and then chaired for a while the all-party group on dementia. I agree entirely with you that dementia is one of those things that we must always be conscious of in any environment in which older people are located. Prison is increasingly going to be one of those.
One of the other notable things about dementia is that diagnosis is notoriously difficult, and general practitioners are reluctant to diagnose it. If general practitioners struggle to make that diagnosis, then we can be certain that prison officers will struggle to do so, however much training we give them. Michael is right that we need to make sure that prison officers feel confident in asking for help and professional input if they believe that that may be what is going on. If we can give them more broadly-based training in mental health issues and a brief understanding at the very least of what dementia may look like—some of the warning signs to look for—then they will need to make a referral at a subsequent point for a more professional determination to be made.
When we come on to talk about how social care and health care may change for prisoners, perhaps we can return to some of those things, but I agree with you entirely that it is one of those things we have to be aware of. I am equally conscious that we cannot

realistically expect prison officers to be experts in all of these different conditions and to make a diagnosis themselves. We want them to spot warning signs and make a reference back.

Q134 Andy McDonald: Mr Wright, what we have found is that people were volunteering to come forward for training. It was not a question of them being screened or it being part of the ordinary scene. We have touched a lot upon the Nacro training pack. Mention was made of it earlier. We did hear that it has disappeared, so we are pleased to hear it is actually on the web. But Nacro are saying that it needs updating because it is 2009 and funding is an issue for them. Perhaps you would like to comment to see how we can assist in getting that valuable resource refreshed.
Michael Spurr: We have commissioned the RECOOP group to do that work. Unfortunately for Nacro, they did not get the funding for that. RECOOP are Resettlement and Care for Older ex-Offenders and Prisoners. They are working at the minute in the south-west in a number of prisons and developing a whole range of web-based information and awareness tools that will be used across the system and will update the 2009 Nacro piece of work.

Q135 Chair: That will effectively replace the Nacro—
Michael Spurr: We will still have the Nacro one. We will determine whether we take that or whether it is a supplement to the Nacro work, but that is the additional work that we are doing to update our awareness work at the minute. The specific contract with RECOOP is to develop best practice and provide tools to be able to share that across the estate.
Jeremy Wright: One of the things we will do is look at the guidance that we will then have—the updated version—and decide whether, first, it is promulgated in as easily accessible a form as it should be, and, secondly, make sure it is as clear as it should be. We will have a look at that, and, if we can do it better, we will.

Q136 Seema Malhotra: That leads me neatly on to talking about health care in prisons. There is research that has concluded, particularly with older male prisoners, that health conditions are worse than those of their equivalents in the community. There has been some discussion of older prisoners described as suffering from "institutional neglect", according to Department of Health definitions. How do you respond to those claims that, in terms of health care, that is what is happening and that prisoners are suffering from this "institutional neglect"?
Jeremy Wright: I would not accept that there is institutional neglect.

Q137 Seema Malhotra: You would not accept it.
Jeremy Wright: I would not accept that. I would certainly accept that prisoners have particularly challenging health circumstances in many cases. Whether they are old or not, we are dealing with a large number of prisoners who over a long period of time have had a drug addiction, for example, which has physical consequences, as we are all aware—and alcohol addictions too.
There are a number of very challenging physical conditions that prisoners may have that make the healthcare challenge within the prison environment more difficult. We also know—and this is something that we have discussed before—that there are too many people in prison with a mental health problem. There is a concentration, if you like, of healthcare problems within a prison environment that makes that a particularly challenging problem.
But we are making continual investment into healthcare facilities within the prison estate and, if you take prisoners with long-term healthcare problems, there are huge challenges in dealing with those, which may be very specialised problems within what will inevitably be a more generalised healthcare environment within the prison. At the very least, we can say that prisoners will have ready and nearby access to healthcare facilities, which perhaps out in the community they might not have had.
It is not all bad news. I certainly would not say that there is institutional neglect, but there are very significant challenges that the prisoner population present to us in terms of health care. Perhaps I should hand over to my colleague at the Department of Health.
Mr Calderwood: One of the biggest challenges is that many people come into prison having had no health care out of prison. Something like 50% of people who come into prison do not have a GP, and so often many people—

Q138 Seema Malhotra: Did you say 50% of those coming in do not have a GP?
Mr Calderwood: Yes. People without a settled way of life—many drug users or people with alcohol problems—may very well not have access to a GP. Their physical and mental health may be very poor when they come into prison. Prison might very well be the first time for some time that they have seen a doctor or dentist. One of the challenges for the healthcare system within prison is that you are dealing, in a sense, with a backlog of health problems for some of the prison population—not for all.

Q139 Seema Malhotra: I understand that culture of not dealing with health services. Can I understand what you mean by saying "no access"? It is not that there is necessarily "no access"; they have not registered and do not use services.
Mr Calderwood: Yes, that is right. One of the challenges for the new health system is, generally speaking, taking a look at some of those groups of people who, for whatever reason, have not really been part of the healthcare system.
The other thing I would say is that, since the NHS took on responsibility for commissioning healthcare services, the evidence seems to be one of substantial improvements in the quality of healthcare services in many prisons. In a sense, the big problem there now is one of consistency. We have examples of excellent practice—and you visited the Isle of Wight and Broadmoor—but you also have areas where practice is not nearly as good as it should be. The creation of

NHS England, where effectively commissioning of all health services within prisons is going to be brought into one organisation, should mean—

Q140 Chair: Can I clarify how that is being done? Is NHS England nationally going to do all the commissioning, or is the commissioning going to be delegated to the area teams of NHS England?
Mr Calderwood: The answer is both. Before April, commissioning was through PCTs—primary care trusts—which are independent of each other. Now, NHS England, as a national organisation, is responsible, but something like its 10 area teams will take responsibility for particular bits of the country and they will work to consistent standards.

Q141 Seema Malhotra: Where an establishment falls within an area, will that area then be responsible for commissioning of the care within the prison?
Mr Calderwood: Yes. There are something like, I think, 27 area teams. NHS England has decided to get 10 of them to specialise in prison health care in order to get expertise and consistency across the patch.

Q142 Chair: There are 27 area teams, but only 10 of them will commission prison health care.
Mr Calderwood: Yes, that is right. There are 27 local area teams. NHS England has asked 10 of them across the country to say, for a larger group, that they will commission all prison health care. They will also have responsibility for aiming to provide a much better integration of healthcare when people move from prison to out of prison and also to look at the relationship with local authorities and social care in that area. We think this mechanism should provide much greater consistency in the kinds of standards that are expected, the contracts that are used, and also to provide a way of getting a better glue into the system, which is also one of the challenges we heard about earlier.

Q143 Seema Malhotra: There are 10 out of the 27 who are taking on the additional responsibility for areas outside their immediate area, and they have additional funding to do that.
Mr Calderwood: Yes. They are responsible. I feel like I am presenting this in a very confused way. The simplest way of saying it is that there are 10 teams that will do commissioning of all health care in prisons covering the entire country, and, if I remember rightly, they will have access to something like £470 million to do that this year.
Chair: Do you want to ask about the IT?

Q144 Seema Malhotra: I do, yes. I want to follow up with one question about integration of systems behind both the justice healthcare systems and the NHS. Is there a move to look at greater integration of patient data?
Mr Calderwood: Yes. One of the challenges, certainly as far as the NHS is concerned, is that the prison healthcare systems are not connected into what is described as the national spine, which enables easy transfer of information. One of the things that NHS England is looking at is the time scale and cost of moving into ensuring that link is made. I cannot give you a commitment now as to when that is going to be because it depends on the money becoming available, but they are hoping that by 2016 that kind of link is effective, which would mean that there ought to be the same sort of connectivity between the NHS healthcare systems and healthcare systems outside prisons that exist across the country.
Jeremy Wright: There is a practical example of that which is very important to the work that we all do in relation to drug treatment. As the Committee will recognise, one of the difficulties that we have with those sentenced to short prison sentences who have a drug addiction is that it is very difficult to start the process of getting someone off their drug addiction if you are only confident that you have them for a very short period of time.
Part of the advantage of not just this better link-up in the transfer of information, but, frankly, also better linking of the work done on rehabilitation more generally in prison and through the gate out into the community, is to be able to start a drug treatment programme even though you know it will not be completed when someone is in prison because you will be confident that you can carry it on outside.
Our two Departments are working closely together on providing this to make sure that we can start that process. We want to see people start the process of getting off drugs as soon as possible. We do not want to maintain them on another form of drug for a period simply because no one is confident that they can complete the process. This kind of linking will have very practical advantages to some of the most significant problems we are dealing with.

Q145 Jeremy Corbyn: Could I take you on to the rather sad area of end-of-life care? There are a number of prisoners who have terminal conditions, mainly cancers. Are you happy with the level of treatment they get, and also what criteria do you use—because I believe it is your decision as a Minister—whether or not to give compassionate grounds for early release?
Jeremy Wright: Yes. On the first part of the question, there are, I suspect, examples of very good practice and examples of slightly less good practice in terms of the end-of-life care that is provided across the estate. Whatton is a good example of a prison that has excellent end-of-life care. The degree to which prisons develop a particular specialism in that may depend on the nature of the prison population they regularly deal with.
If you have an older prisoner population, this is a problem you have to confront more often than if you have a younger prisoner population. There are examples of very good practice, and we would always seek to make sure that those examples are communicated across the estate and replicated wherever we can. But certainly there will be variation and we will want to try and iron out that variation where we can, recognising that not every prison will have a regular experience with this, whereas other prisons will be more regularly confronting it.
In so far as the question of compassionate release for those who are terminally ill is concerned, you are right that it is, in the end, my decision. I have had to make

that choice on one occasion so far since I became a Minister. The judgment I have to make is about, first of all, whether or not the prisoner is going to present particular security problems if we were to release them, but also about whether or not they are significantly incapacitated or clearly very terminally ill and how imminent their likely death is. This is the difficult bit because, inevitably, the medical evidence that we are likely to receive will give us an estimate as to how long someone has left.

I have to make a judgment as to whether or not that is the appropriate moment for them to be released, effectively to go home to die, because the public would expect me, first of all, to be compassionate in making sure that I allow someone to go home to die if that is what they choose to do, but also to make sure that I am not releasing someone far too early and they end up being outside prison for a very considerable period of time.

It is a difficult judgment to make and it is never as easy as the doctors telling me exactly how long someone has left to the day so that I can make that judgment. The guidance is that we would look to release someone who has about three months left to live, but, inevitably, as I say, what you tend to get is a bracket of between a certain length of time and another length of time. So it is a difficult judgment to make. The judgment that I made in the one case that was brought to me was that it was appropriate to release that person, but it was a range of potential time that that person had left. Again, it is always a judgment that has to be made on the facts of each individual case, and I think it is right that the Minister with responsibility for this area makes that judgment themselves.

Q146 Jeremy Corbyn: Do the applications automatically come to you, or can they be dealt with at an earlier stage or, indeed, rejected at an earlier stage? In other words, are the prisoners aware that, ultimately, it is a ministerial decision?

Jeremy Wright: There are not many of those judgments.

Q147 Jeremy Corbyn: I know I have written to you about one case.

Michael Spurr: They have to be recommended by the governor. The governor has to be satisfied in the first instance that this is a case that merits referral to the Minister for compassionate release and would look at exactly the same criteria.

Q148 Jeremy Corbyn: If the governor is not satisfied, does it not go any further?

Michael Spurr: No. The case for satisfaction is: is there clarity about length of time? That is always the issue. Are doctors able to say that, while somebody is terminally ill, they have a limited time left? That is the difficulty. That is often why referrals do not get made, not because governors are unwilling to make the referral but because no one is able to say at that point whether a terminal illness is two years or two months. That is always the hard thing. I can well understand why doctors do not want to commit to what that length of time is, but the criteria is that, generally, we are looking at releasing people who have a few months to live as opposed to potentially a lot longer period than that.

Q149 Jeremy Corbyn: Would it be fair to say that governors, in general, are not minded to want to keep terminally ill prisoners on their estate?

Michael Spurr: In general, you would rather not have a terminally ill prisoner because of the impact that has on managing the individual and on the resource involved in managing the individual, particularly if they have to go out to hospital routinely and so on. That is the case, but the reality is that we have a significant number of terminally ill individuals inevitably because we have 80,000 or so people in custody and we have a number who are over 60.

Therefore, most establishments—and particularly those establishments that often have a sex offender older population—have well-established procedures in place for managing people who become potentially terminally ill. We have specific end-of-life centres. There is one on the Isle of Wight in the healthcare centre; there was one in Norwich, which was developed in the late 1990s; and there is Whatton as well, where there have been a number of deaths that have been managed through that process.

Jeremy Wright: It is probably worth saying two other things, one of which perhaps is very obvious. In relation to the judgment to be made about compassionate release, we have to take into account the sensitivities of victims as well. There is an inevitable balance to be drawn there.

The perhaps less obvious point is that there are a number of prisoners who would prefer in fact to die in prison. If they have been in prison for a very long time and they consider that to be, effectively, their home environment, they may wish to exercise the choice to die there. It is not the case that every terminally ill prisoner dying in prison has died in prison because we have not released them as we should have done or have not considered their case properly. In many cases, it has been considered and the choice of the prisoner concerned is that they wish to die in that environment. It is a very sensitive issue.

Q150 Jeremy Corbyn: If a governor declines a request for compassionate release, does the prisoner have a right of appeal against that, or is it an administrative matter that it simply could not go any further because the governor has said no?

Michael Spurr: They have a right of appeal to the Prisons and Probation Ombudsman on that basis. If it is a time-limited issue, it is not unusual that they might even seek a judicial review if they were not happy with what had occurred. But the normal process would be that they would appeal it through the normal complaints process, and, if the governors determine that that is not right, that would go to the Prisons and Probation Ombudsman to look at.

Q151 Chair: Can I turn to the social care issue? The Committee was quite shocked to discover the extent to which in the system up to now nobody was taking responsibility for personal care for those prisoners who could not carry out basic bodily functions

without assistance and in the community would have had direct support for this purpose. The result was that prison officers were confronted with a situation in which they were not supposed to provide the assistance and the only other recourse was other prisoners providing that assistance, which itself can present some problems with some of the categories of prisoners we are talking about—particularly sex offenders. The Health and Social Care Bill is intended to solve this problem, so we are interested to know whether it is going to do so.

I suppose the first question is the money. Some local authorities will suddenly find themselves confronted with hundreds of people for whom they have to provide, or may have to provide, personal care. Somewhere like the Isle of Wight, for example, have a big commitment. How is this going to be managed?

Jeremy Wright: I will defer to Dr Calderwood to give you some detail, but my understanding is, first of all, I think you are entirely right that the current situation is deeply unsatisfactory and it is important that we resolve whose responsibility social care within prisons should be. I believe the Bill does do that because it makes it clear that the local authority within which the prison is located will take on responsibility for social care for prisoners within that prison.

So far as finance is concerned, my understanding is that the baseline funding for those local authorities will be increased to make allowance for that extra responsibility, but I will perhaps let Dr Calderwood explain in a little more detail.

Mr Calderwood: Yes. In terms of funding, the estimates that have been made so far are that there is an additional cost to local authorities of £8.6 million. However, that is based on limited evidence. What we are currently doing is looking to get a better handle on that cost and then our intention will be to transfer that money, whatever the additional cost is, to the baselines of the local authorities who have prisons in their areas.

Q152 Chair: That is £8.6 million that should be being spent now because, theoretically, the local authorities from which the prisoners come have a responsibility for their personal care, but it is not being carried out in most cases and is rather impractical on that basis for a local authority at one end of the country to provide personal care to a prisoner at the other end of the country. In theory, the money would be being spent already, but actually it is not, is it?

Mr Calderwood: The whole point of the current law is that it is not clear as to whose responsibility it is, which is why, through the Bill, we are making it absolutely clear that it is the job of the authority where the prison is to take on the process of assessment and responsibility for the provision of whatever are the care needs of the person.

Jeremy Wright: It is probably worth saying that there are examples where local authorities in fact do this job effectively. I do not think it is true to say that in every case there is no adequate connection between the local authority and the prison to provide this care. Of course some of it is done by prisons buying in the help that they need. Some of this money is already being spent, but I think we are all agreed that it is not being spent as effectively or as clearly as it should be. One of the advantages of making these changes, it seems to me, is in connection with the changes we would want to make in any event to resettlement prisons, to ensure that prisoners are spending the last part of their sentence in a prison in the area into which they are going to be released. It means that we will be able to ensure that the social care that they receive will come from the local authority—at least in the last part of the sentence—which will then take on responsibility for them out in the community.

Q153 Chair: Except that there are not as many prisons as there are local authorities, so even an appropriately placed resettlement prison will perhaps be in an area of five or six local authorities.

Jeremy Wright: That is right, but we are going to get a lot closer to it and will be able, I hope, to enable the local authority to travel a little less distance to get to the prisoner for whom they are going to take responsibility than they currently have to. Also, there will be a huge benefit in the portability of assessments so that assessments made on a prisoner while they are inside prison will be able to be taken on in the system to the assessments that will be made when they leave, which, as we know, is a huge problem at the moment.

Q154 Chair: Does that mean, in effect, that the common assessment framework that we found operating—I think successfully—in the Isle of Wight is a model that is going to be taken out elsewhere?

Michael Spurr: It is that type of model. There should be one assessment that is done, and, if it is done in prison, it moves with the individual because of the need to move with the individual when they are going back into the community; so, yes.

Chair: That is good news.

Q155 Andy McDonald: Can I turn to the issue of equality and the human rights legislation, particularly on the issue of age now being a protected characteristic under the Equality Act? Governors are required to produce an equality plan that expects people to be treated equitably, and consulted and treated according to their needs. We have heard evidence from Leigh Day's prison team that, in their experience, there had been evidence of unlawful discrimination, but historically it was on the grounds of disability. Of course age is now effective as from October 2012. I stress that we are not talking about, "I want my Sky TV"; it is about people who cannot get to the shower or who cannot take their meals, which are fairly fundamental issues.

How many claims on the basis of age discrimination have been made by older prisoners since the relevant provisions of the Equality Act came into force in October 2012?

Michael Spurr: We do not have figures for claims that are solely about age discrimination. It is, though, possible that claims for specific issues may have an age-related point within them and we cannot differentiate those at the minute from our statistics; we do not pull those out. I am not aware of straightforward age discrimination claims. As you say,

age specifically was introduced in October 2012, so in one sense that is a relatively short period before you would expect some claims.

Q156 Andy McDonald: Would you expect there to be an increase in those claims coming through on the basis of older prisoners being unable to participate in—

Michael Spurr: I would want us to make sure that we did not do anything that would lead to the claims in the first place, but it provides a means by which people who feel they have not been treated properly can challenge that, in addition to the existing arrangements.

As I said, if we are not providing access to showers because somebody is older or disabled, that is unacceptable—and it always has been. On our basic standards, there is nothing in age discrimination legislation that changes what we would have been required or aiming to do anyway. We have to treat prisoners of whatever age appropriately and with decency. From that perspective, our aim has always been to do that. This will make it even clearer. There is a remedy for people to tackle that where we do not do that.

Q157 Andy McDonald: Would you accept the observation that few establishments are DDA-compliant in any event—that many of them are not DDA-compliant?

Michael Spurr: I would accept in physical conditions terms that that is difficult. Our responsibility is to be able to provide reasonable adjustment to any individual so that they are not disadvantaged. That is how we address that issue.

Jeremy Wright: In the end, if it is impossible to accommodate a prisoner with particular mobility problems in a given prison, then we would need to transfer them to a different prison. That is what happens.

Mr Calderwood: I used to be responsible for the Disability Discrimination Act. You can have physical challenges in a building, and the responsibility is then with the service provider—in this case, the prison—to make reasonable adjustments that take account of those physical challenges. If you can put in ramps and things like that, you should do so. If you cannot do that, you would have to find some other ways of enabling somebody to have reasonable access to the same sorts of services that other people have.

Q158 Andy McDonald: It is pretty difficult in Dartmoor where it is a listed building and the chief planning officer will not let you touch it.

Michael Spurr: What were the prisoners in Dartmoor not able to access that was detrimental to them compared with an able or younger person who was able to access them? That would be the question for me. It means providing for the needs of the individual, notwithstanding whether they are disabled, older or whatever. Sometimes that is more difficult and you have to do it in different ways. That is equally true for people who have committed different types of offences. If you separate people, the access to the full range of a regime in a prison will not be there, but we have to provide sufficient to be able to meet the needs of that individual, not to adversely impact on them because we have decided to separate them for whatever reason.

Q159 Seema Malhotra: We touched on this slightly before when we were talking about outcomes, and one of the outcomes you talked about was resettlement. There have been various criticisms of exits from prison and of older prisoners, including health care, housing, jobs and so on. There have been some HMI Prisons reports that have criticised the resettlement provision for older prisoners. What steps has NOMS taken to remedy some of these concerns, and are you focused on any particular issues at the moment? Is any one of them a priority for you?

Michael Spurr: Our whole strategy on resettlement has been for everybody who is leaving a prison to be supported on their resettlement. I mentioned earlier—forgive me for returning to it—that the significant issue for me that the HMIP had raised about older prisoners was particularly around social care when moving back into communities and the fact that that was not always sorted out before they left prison. Similarly, it is the ability to be able to apply for benefits, including pension benefits, for example, in advance of leaving custody. We have addressed those issues. You can now apply for benefits in advance, and the Health and Social Care Bill will deal with the portability issue.

In terms of the wider resettlement provision—the Minister may want to speak about it—the whole aim of the "Transforming Rehabilitation" programme is to significantly expand resettlement provision for all prisoners by switching the responsibility such that the providers who will look after and support people in the community when they have left prison will be responsible, paid for partly by results, for those individuals in prison.

Our aim is that, as we move to these new arrangements through the reforms in the community and probation, the through-the-gate service will be a provision that comes into prison with providers who are responsible for those who are going out. That should mean a better holistic service provided to all prisoners, including older ones.

Jeremy Wright: That is absolutely the case. When we talk about resettlement, there are a number of elements to it. There is no doubt, as we have said before, that in relation to housing and employment there are very particular challenges that older ex-prisoners present for us. The clear impetus of the "Transforming Rehabilitation" agenda is to persuade providers to say, "Look, it is in my interests to ensure that this individual does not offend again. If I am going to succeed in reducing the likelihood of that individual reoffending, I need to look at what are the factors that might make it more likely that they would reoffend."

We know for certain that getting a stable place to live and having employment that you are able to hold on to are key factors in determining whether or not someone is likely to reoffend. If you are a provider charged with that task and incentivised to complete it successfully, those are the things you are going to

want to focus on. I have every confidence that providers who are looking after older offenders will be focusing on that kind of thing.

The other reason why I am confident about that is that, if you look at the statistics for completion of licence conditions and obedience to court orders, those figures are much higher for older offenders than younger ones. That, perhaps, is not so much the issue as getting the nuts and bolts of daily life right.

One of the challenges that we are going to have to grapple with increasingly as we deal with an older population of prisoners is that those leaving custody may not simply require a flat or a room in a house somewhere; they may require a more supported form of housing, whether that is residential care or something else. It is making those sorts of arrangements for either very old prisoners or prisoners with significant disability that is going to be the real challenge.

But, again, we will expect providers to do that. They will not be able to pick and choose the offenders that they are responsible for. They will be responsible for those offenders who come out of a number of resettlement prisons into a given geographical area. If that increasingly includes a number of older prisoners or prisoners with problems of the nature we have been describing, they will need to address those problems.

Q160 Seema Malhotra: Could I probe that a little further? Will it be the provider's responsibility to find suitable housing as well? Could I ask as well to what extent you are still releasing prisoners to "No Fixed Abode" and whether you are considering any legislation, as with Wales, so that that does not happen any more?

Jeremy Wright: On the latter point, we are not always able to be sure that someone has a permanent address that they go to, but they are never released without the criminal justice system being confident that we know where they are, because licence conditions may very well include release to a particular address. We would need to be satisfied that they are released to a suitable address even if it does not turn out to be a permanent address.

Housing will remain the responsibility of the local authority. The local authority will still have an obligation to house someone. We are not seeking to change that. I think that a provider will see it as very much the right thing for them to be working closely with the local authority to help provide that housing. As I say, it is very clear to everybody when they look at the evidence that a lack of a stable address is a clear warning factor as to the likelihood of reoffending. So you will want to make sure that someone is accommodated somewhere stable; if it cannot be in a private address, then I would expect providers to be working with local authorities that are the housing authorities to provide housing through that route.

Q161 Seema Malhotra: Are your providers going to have the training and awareness to deal with particular types of prisoners or those with particular records? One example might be sex offenders where there might be particular concerns and also the need for access to treatment programmes. Are they going to be aware of this?

Jeremy Wright: Yes. The answer is that we will not allow any bidder to be successful who has not persuaded us that they have staff and systems of the requisite quality to do the work.

There is obviously a variety of different sex offenders. For those offenders who are categorised as causing a high risk of harm to the public, the public sector probation service will retain the management of those offenders. We are talking about medium and lower risk offenders that providers would be dealing with in the contracted space. But certainly we will expect all providers who want to take on this work to persuade us and convince us that they have understood the variety of different needs that there will be among the offenders that they deal with—that is whether we are talking about the age of the offender, other particular personal characteristics or the nature of the offences that they have committed—in order to persuade us that they are suitable people to take on the work. So, yes, we will be interested to know what they intend to do for sex offenders as a particular group, but they will not be managing those sex offenders who are a higher risk anyway.

Q162 Chair: There are some people convicted of sex offences who maintain that they did not commit those offences and, as a result, do not have access to the programmes that might assist in their resettlement. One witness told us that NOMS is going to produce a new programme to which deniers could have access. Can you tell us anything about that?

Jeremy Wright: Yes. I will let Michael speak about it in more detail, but there are two groups here effectively. There are those who partially deny their offence or have minimised it, and they will be able to have access to a number of the programmes that are currently running because they can be provided in such a way that those sorts of prisoners can still access and benefit from them. Those who deny their offence absolutely have, as you know, been a persistent problem for some time, and we are working on a programme that would be suitable for them. I will let Michael talk about the detail.

Michael Spurr: The difficulty with someone who is absolutely adamant that they have not committed the offence means that the starting point for being able to address what led to the offence being committed does not exist. From that perspective, we cannot deal with a sexual issue if someone is saying, "It wasn't me, guv, who did that." In the past, we have taken that too far in terms of those who minimise their offences.

A lot of people accept that other people might have thought they had done wrong but they minimise that offence. With that type of denial, in the past we might have said, "You are not open enough for treatment and we will not treat you." We are now being very clear that our programmes can deal with that. In fact, it is not unusual for most of us when we do something wrong to minimise, for our own humanity, how we got that wrong. It is certainly an issue for sex offenders that they will minimise offences. We are much clearer in our treatment models now that, because they are minimising the offence, it does not

mean to say we cannot put them through treatment. That is one of the things you can address in treatment. For those who are saying, "I am not guilty of this offence and I wasn't there," or whatever, we are into wider offending behaviour programme-type work that can address general issues but will not be able to address the specific offence. If you are denying the offence, it is incredibly difficult—or impossible, I would say—to be able to do that.

Q163 Chair: Thank you. While we have you here, Minister, we would like you to update us on the situation that has arisen as a result of the electronic tagging contract revealing something wrong, as a consequence of which the announcement of the approved bidders for prisons in Yorkshire and Northumberland—in my constituency, as it happens—has been delayed. How serious are the problems that have been identified with electronic tagging contracts? When will we know more about the outcome, and when will you be in a position to complete the bidding process?

Jeremy Wright: The answer to when we will be in a position to know the outcome in relation to the electronic monitoring investigations that we are carrying out is difficult to give, because at the moment not only are our resources deployed on this but we also have an external audit presence to investigate what has happened here. We need to get to the bottom of it and work out what the appropriate response should be. As a result of that, it is very difficult to be precise about timing.

All I can say is that it is important that we carry out that work thoroughly and, as I say, that there is a degree of external scrutiny applied too. That is already under way. Once that is done, we will be in a much better position to update the Committee, but I cannot say at the moment what the outcome of that scrutiny will be because it is not yet complete.

Q164 Chair: That means that prisons whose future management was expected to be decided already are in a state of uncertainty that could be prolonged, and the prison officers who work in them cannot really find out anything about what their future career pattern is going to be and who is going to employ them.

Jeremy Wright: I am very conscious of that and we want to complete the work as quickly as we possibly can, but the Committee will fully understand that it is important we also make sure that the audit process that is under way at the moment is done comprehensively so that we are in a position to reach the appropriate judgments. We will do these things as quickly as we can, but we must also make sure that they are done properly. I am very conscious that there are people waiting to find out what the outcome of that particular process is going to be and I do not want to keep them in suspense any longer than is necessary.

Q165 Chair: Would it be better to delay by a specified period the time at which these prisons might be handed over to the bidders?

Jeremy Wright: The first thing to do is to assess how long it is likely to take to complete the audit process that is under way. If it takes considerably longer than we have anticipated, of course we will revisit the question. But at the moment the important thing is to make sure that we complete our audit processes, that we do them comprehensively, reach the right judgments on those things, and then we will move ahead as quickly as we can.

Q166 Chair: Doesn't this illustrate a wider problem that the Ministry of Justice is going to face? If a limited number of public service contractors contract for a range of the services that come within the scope of the Department—interpreting, electronic tagging, probation and the management of prisons—you are at risk of this happening more often, where, because the numbers involved are few, you cannot proceed according to your original plans to allocate contracts because something has gone wrong in one of the other areas affecting the same small number of businesses. How do you view that difficulty?

Jeremy Wright: I do not think it follows that problems in one area make it impossible to proceed in another, but, until we have completed the particular audit process that we are proceeding with at the moment, it would not be right to move our resources elsewhere.

The other point is that in relation to the "Transforming Rehabilitation" agenda, where it is perfectly right that we are looking to involve a great deal more outside organisations in the business of delivering rehabilitation, we conduct at the moment a number of events with those who have an interest in providing these services, and I quite often speak and answer questions at them. I am rarely talking to an empty room and am usually talking to a very full room. My expectation is that there will be a large number of organisations that will play a part in this—perhaps not on their own but more probably in partnership with others.

We are not looking to create an environment for "Transforming Rehabilitation" where it is only one or two organisations that provide this service. We are looking to create an environment in which a number of organisations will provide that service and that gives us precisely the type of resilience you are describing.

Chair: Thank you very much.

Written evidence

Written submission from Dr Azrini Wahidin, Reader in Criminology and Criminal Justice, Queen's University, Belfast

Appropriate Age Cut-Off

Much of the debate on older offenders is over how to define "old". The definition of "elderly", "elder" or older, can produce information which at first appears contradictory.

An extensive review of the literature reveals that some previous researchers have defined older prisoners as those 65 years of age and older (Grambling and Forsyth 1988; Newman 1984a), some 60 (Kratcoski 1990) and some 55 (Goetting 1992). However, the majority of studies such as Aday, (2003), Wahidin, (2002), Phillips (1996), the American Department of Justice and older units for older prisoners in the UK and in the States have used the age 50–55 as the threshold age to define when one becomes an older offender. Aday (1994), conducted a national survey of State prison departments and found that 50 years of age was the most common criterion for old age that prison officials utilise. Similarly, Wahidin (2002, 2004) found in a national study of men and women who are over 50 in prison in the UK that prison officers, healthcare personnel and governors running older units, defined older offenders as 50 and over.

Furthermore, UK healthcare statistics show that from the 50–80+ age group, the 50–59 is the most costly age cohort in terms of bed-watches required and medications consumed (Wahidin 2005), underlining the usefulness of a cut-off point which enables this age group to be included within the definition of 'older'. This definition is further supported by the fact that offenders experience what is known as 'accelerated' ageing so that a typical offender in their 50s has the physical appearance and accompanying health problems of someone at least ten years older in the community.

Studies have shown that on average the cost of keeping an elder in prison runs over three times that of a young adult in prison (Dubler 1988). The specialised medical care for elders varies from simple needs such as hearing aids and dentures to more expensive items such as high-cost prescription medication, prosthetic devices and wheelchairs. At the far end of the cost spectrum are the needs of Alzheimer's sufferers and critically or terminally ill prisoners. For these reasons, Morton (1992), and prison health-care personnel and prison officers in the UK (Wahidin 2004, 2005) stipulate that 50 is the ideal starting point to initiate preventive health care and is the point to take appropriate measures to reduce long-term medical costs for older offenders.

2. Older Prisoners in the UK

The literature available on older prisoners is still restricted to predominantly American-based research (Aday, 1995; Anderson and Morton, 1989; Newman, 1984). The work of Aday (1979, 1994a, 1994b) in the USA has been of particular importance in addressing the increase in older people committing crime and the challenges the ageing prison population poses to correctional facilities, and is discussed in some detail below.

The majority of the over 50 and over prison population are serving sentences between four years and 'life'. The 60 plus age group has become the fastest growing age group in the prison population (Ministry of Justice, 2007), with the number of men more than tripling between 1996 (699) and 2008 (2,242) (Prison Reform Trust, 2009). This compares to a one and a half times increase among the under- sixties prison population. The majority of men in prison aged 60 and over (56%) have committed a sexual offence. Out of all the 60–69 year old prisoners, 52% have been imprisoned for sex-related offences and among the over-seventies it is 73% (Prison Reform Trust, 2009). More than one in 10 male older prisoners who are 60 and over belong to a minority ethnic group, which is far higher than the proportion of the general population (Prison Reform Trust, 2007). At the end of August 2007, the oldest male prisoner was 92, while 454 were over 70 years of age (Prison Reform Trust, 2009).

From 1999 to 2008, the older prison population more than doubled from 3,000 to over 6,000. This increase in the older prison population is not explained by demographic change but is a consequence of harsher sentencing policies which have resulted in courts sending a larger proportion of criminals aged over 50 to prison to serve longer sentences (Howse, 2003b; Wahidin and Aday, 2005, Wahidin, 2006). This has been especially the case in relation to sex-related offences including men in later life charged with 'historical offences' (offences committed two/three decades ago) and drug traffickers (Ministry of Justice, 2007). The women's prison population in England and Wales stood at 4,390, representing 5% of the total prison population. Out of the 316 women aged over 50 who are in prison in England and Wales, nearly half are foreign nationals (44%) with many serving sentences for importing drugs (Prison Reform Trust, 2009).

3. Segregation Versus Integration

The USA has been at the forefront of delivering special programmes addressing the needs of older offenders (Krajick, 1979; Aday and Rosenfield, 1992). In this sense, 'special programmes' constitutes the distinctive treatment of the elderly prisoner housed in an age-segregated or in an age-sensitive environment. Elder housing placements are typically based on a clinical criteria based on medical need. Rather than relying strictly on age, most states take the length of sentence and physical condition into consideration when prisoners are classified,

custody graded, and given work programmes or housing assignments (Flynn, 1992, 2000). The main question for prison administrators concerning ageing offenders in prison is whether to mainstream or segregate this population. One argument is that segregated housing provides a concentration of specialised staff and resources for the elderly, thereby reducing costs (Florida Corrections Commission 2001). Previous research supports the notion that participation in a specific group increases self-respect and increases capability to resume community life once released. A choice of age segregation or age integration provides older prisoners with the opportunity for forming peer networks, while at the same time reducing vulnerability and violence they may encounter in the mainstream of prison life.

Management challenges of ageing prison populations: the response of the UK

In the case of the United Kingdom, it is evident from the report *"No Problems—Old and Quiet: Older Offenders in England and Wales"* (HMICP, 2004) that people aged 50 plus are a significant group within the prison population. However, the subsequent report (HMCIP, 2008) found that many of the key recommendations made in the earlier document had not been acted upon. For example, one of the key areas identified concerned the extent to which the prison environment was failing to reflect the needs of those with age-related impairments and disabilities. The Inspectorate Team found that in the majority of the prisons there were no separate regimes for older prisoners and that many were excluded from a range of activities and remained locked in their cells during the day. Another key area for concern was the general level of health of older prisoners and healthcare provision. In some cases, prison healthcare centres were being used inappropriately to house older and/or disabled prisoners. Mental health difficulties are also a major issue. Over half of all elderly prisoners have been diagnosed with a mental illness, the most common being depression, which can itself emerge as a result of imprisonment (Prison Reform Trust, 2009).

3. Resettlement

The reports from the Inspectorate Team also highlight the lack of adequate resettlement programmes for offenders in later life. Prison Service Order 2300 (para.1.12) states *inter alia* that account must be taken of the diversity of the prisoner population and the differences in resettlement needs, and that specific cohorts of the prison population (eg, elderly prisoners) may need be catered for in different ways. However, Aday, Dayron, and Wahidin, (2009), and Mann, (2009), have highlighted that older men and women in prison often experience anxiety as release becomes more imminent. Many elderly offenders—especially men who are convicted of sexual offences—feel that they are more vulnerable to assault when released. Many feel that they have nothing to go out to and that for them 'time is running out' (Aday, Dayron, and Wahidin, 2009; Wahidin, 2005;Aday, Dayron, and Wahidin (2009) found that some older offenders exhibited a profound sense of fear and despair at the prospect of dying in prison. So the question that must be asked is 'what sort of life is left for those who *know* that a life after prison would never be a possibility? Thus for older men and women in prison, release and resettlement is not an unproblematic issue but a highly complex one. The two key issues facing the older offender due for release are: first, the lack of clarity from prison and probation staff *as* to where they are going to live, with *whom* they will be living, and *how* they are going to get there. Secondly, many elderly prisoners have little idea as to what they are supposed to do once released, or what (if anything) has been arranged for them when they get out. The majority of prisons in England and Wales have virtually no resettlement schemes geared for the elderly offender, and no account is taken of the need for older prisoners to manage, often by themselves, with disability or illness, or loneliness and isolation (Gallagher, 1990; Howse, 2003b). At the time of writing (2009) there is no national strategy to develop such courses for older prisoners to ensure equality of access for this age group. It is important to note that due to the relative compliant nature of this prisoner group, their specific resettlement needs are being overlooked. In the above studies, the knowledge that time is running out makes both the prison experience and the resettlement process for older men and women different to that of the younger population.

The UK experience suggests continued reliance on the initiative of committed prison officers, with an assumption that the care of older prisoners, including their social care, is a matter for the health services rather than that of the prison service. Since 2004, prisons in England and Wales have been subject to the Disability Discrimination Act (DAA), which requires the prison service to take all reasonable steps to ensure that prisoners with disabilities can access services. In consequence, the Prison Service has issued orders (PSO 2855 and PSO 8010) detailing the steps prisons should take. The National Service Framework (NSF) for Older People (Department of Health, 2001) also identifies the need for prisons to provide for the health and social care needs of prisoners over 60. Yet it is evidence from the official reports in this area that few prisons are reaching the standards required in legislation, though progress could be identified in some cases (HMICP, 2008; Prison Reform Trust, 2009)

Future Issues and Recommendations

As the number of older offenders participating in the criminal justice system accelerates, developing social policies to respond effectively to the group will become critical.

To alleviate some of the problems associated with imprisonment, the prison authorities should be turning their attention to literature relating to residential homes or assisted living facilities (Aday, 2003; Atherton, 1989; Coleman, 1993; Hockey, 1989). There are many simple measures which could be taken that would allow

elders control over their immediate physical environment, for example: installing doors and windows which they could open easily, and radiators which they could adjust themselves; replacing the harshness of the prison corridors with appropriate carpet tiles; use of electricity sockets which would allow all elders the opportunity to listen to the radio; televisions with teletext for the hard of hearing, electric hoists, and replacing the glare of the strip light with something less harsh. Such measures would at once make prison a less hostile and more accessible place. In addition, due to the impairment of sight, hearing, memory, and reflexes, as well as the general slowing of movement and mental responsiveness, elders need to be cared for by staff members who are specifically trained in the needs of elders in prison. Mental and physical assessment, counselling services, and other programming will be necessary. For prisoners who will spend the rest of their lives in prison, managing their health care will become a critical issue. Prison officials will be faced with the problem of finding suitable work and recreational activities so prisoners can pass the time in reasonably good health. Of course, prisoners who have spent a greater portion of their lives incarcerated will need intensive discharge planning and community placement orientation. Locating family or community agencies who will accept ageing prisoners eligible for parole will be a challenge.

The limited knowledge concerning the elderly, and the absence of relevant policies and planning in this area, lead one to suggest that the criminal justice system should be turning its attention to:

- An examination of existing formal and informal practices regarding older prisoners, as the first step in developing an explicit and integrated set of policies and programmes to address the special needs of this group across jurisdictions. This will enable a national strategy to be implemented and good practice to be identified.
- Developing a comprehensive and gender and age-sensitive programme for elders that fosters personal growth and accountability and value-based actions that lead to successful reintegration into society.
- Preparing all personnel of the criminal justice system to understand and appropriately address elder-specific topics and issues.
- In terms of being able to address the needs of elders in the criminal justice system, prison units should be able to institute the following:
- Adoption of the age of 50 as the chronological starting point in a definition of the older offender.
- Compiling of comprehensive data on the over 50s from arrest to custody, through to re-entry into wider society.
- Introduction or expansion of specific programmes, policies, and facilities geared towards the needs of older people.
- Identification of the costs of long-term incarceration of infirm prisoners and the potential risks of early release or extended medical furlough for this population.

Even as I write this briefing paper the Prison Service in the Uk, is still yet to have a national strategy for this cohort even though the Disability Discrimination Act (2005) now applies to prisons few establishments are compliant. There are big questions to ask in the context of the global recession, notwithstanding the notion of 'invest now for longer term gains'. Thus in order to comply with the European Convention of Human Rights Convention, policy makers must address the needs of the ageing prison population or be accused of discrimination on the basis of age and, at worst, be accused of contravening Article 2 (right to life) and Article 3 (right to be held in conditions that do not amount to inhuman and degrading treatment). As Wahidin (2004, p. 196) pointed out, 'so many have faded into anonymity' and are now all but forgotten. It is well known that the proportion of the elderly in the general population has increased. However, research, policy initiatives and programmes targeted at the elderly criminal have not kept pace with this general movement. Age, in time, will be considered one of the biggest issues that will continue to affect the criminal justice system and prison health care in the future.

February 2013

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Written submission from HM Chief Inspector of Prisons

SUMMARY

— HMI Prisons is an independent inspectorate and every prison inspection assesses whether older prisoners are treated equitably according to their individual needs. HMI Prisons has found that the needs of older prisoners are too often neglected. Our submission is based on individual inspections and two thematic inspections on the treatment and conditions of older prisoners.

— Our inspection evidence suggests that because older prisoners are a largely compliant population, their specific needs may be overlooked in a system geared towards managing the much larger proportion of younger men. This remains a central issue today.

— The needs of older prisoners and a supporting framework to meet these needs have not been clearly defined by a national NOMS strategy. This has resulted in significant variation across the prison estate in service provision for older prisoners.

— A national NOMS strategy on older prisoners should set out a clear framework for delivery, define the responsibilities of the prisons and other agencies involved and include a common system for assessing the needs of older prisoners.

1. We welcome the opportunity to submit information to the Justice Committee's inquiry into older prisoners. The needs of older prisoners are neglected too often and the lack of a clear strategy and defined responsibilities mean their treatment and conditions are frequently inadequate.

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMI Prisons has a statutory duty to report on conditions for and treatment of those in prisons, young offender institutions and immigration detention facilities. HMI Prisons also inspects court custody; police custody and customs custody (jointly with HM Inspectorate of Constabulary); and secure training centres (with Ofsted).

3. HMI Prisons is one of the organisations that deliver the UK government's obligations arising from its status as a party to the UN Optional Protocol to the Convention Against Torture. OPCAT requires state parties to implement a system of independent, preventative inspection of all place of detention.

4. All inspections are carried out against independent criteria based on relevant international human rights standards and norms which are known as Expectations. Expectations are brigaded under four healthy prison

tests: *Safety, Respect, Purposeful Activity and Resettlemen*t. Our Expectation for older prisoners is that they are "treated equitably and according to their individual needs".[1]

5. In addition to individual inspections, we carry out thematic inspections into cross-cutting themes. We have carried out two thematic inspections into the treatment and conditions of older prisoners. The first, "*No problems—old and quiet*" was published in 2004[2] and a follow up inspection which assessed progress was published in 2008.[3] Our evidence is primarily based on individual establishment and thematic inspection findings.

Background

6. As of 30 September 2012, there were 9,913 prisoners aged 50 or over in England and Wales. This number included 3,333 aged 60 and over. Prisoners aged over 50 make up 11% of the prison population and this has risen from 7% in 2002. Prisoners aged 60 and over have almost doubled since 2002[4] and are the fastest growing age group in the prison estate.

7. The title of our 2004 thematic report "*No problems—old and quiet*" came from an entry into a prisoner's wing file. It reflected the reality that because older prisoners are a largely compliant population, their specific needs may be overlooked in a system geared towards managing the much larger proportion of younger men. This remains a central issue today. Now as then, older prisoners are not to be stereotyped. We find many that are active and determined to be as independent as possible. However, our inspection findings support the conclusions of much other research. In general:

- older prisoners are more likely to have health problems than the rest of the population and may have restricted mobility;
- the effects of crime and victimisation against them are more serious because of the frailties that may be associated with their age; and
- they are unlikely to be in work and training, have less income and may be isolated from friends and family.

8. For the purposes of inspection we consider older prisoners to be those aged fifty and above. This is because research[5] suggests that using 50 years of age as a cut-off recognises that people age quicker while in prison; by up to 10 years more than their biological age prisoners age.

Whether responsibilities for the mental and physical health and social care of older prisoners are clearly defined

9. The needs of older prisoners and a supporting framework to meet these needs have not been clearly defined by a national NOMS strategy. This has resulted in significant variation across the prison estate in service provision for older prisoners. Strategy appears to be developing at a local level, but there is no direction or coordination. During our most recent inspection of HMP Wandsworth[6] we found that although there was an extremely diverse population, there was no strategy to ensure that the various needs of prisoners with protected characteristics were being identified and met. As a consequence for example, we found older prisoners who had not been able to access a shower for some weeks. In comparison, our most recent inspection of HMP Kirklevington Grange[7] found a whole-prison needs assessment had been carried out within the previous 12 months and there was an effective single equality scheme with good promotion of each diversity area. Older men could request to be placed on quieter wings and there were designated activities such as gym sessions.

10. The needs of older prisoners not only encompass mental, physical, spiritual and social care needs but also wider practical, social and resettlement needs. Currently, prison responsibility appears shared between healthcare departments and equalities officers but the approach is often unsystematic and disjointed.

11. Service provision to address the health and social care requirements of older adults has been defined in the National Service Framework for Older People (DoH, 2001) (NSF).[8] It highlights the importance of good liaison between prison healthcare staff and their colleagues in health and social care organisations in the community, to ensure that prisoners who are being released are assessed for and receive services which meet their continuing health and social care needs. However, adoption of the framework in prisons has been patchy.

1 http://www.justice.gov.uk/downloads/about/hmipris/adult-expectations-2012.pdf?type=Finjan-Download&slot=00000123&id=00000522&location=0A64420E

2 http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/hmp-thematic-older-04-rps.pdf?type=Finjan-Download&slot=0000012B&id=0000052A&location=0A64420E

3 http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/older_prisoners_thematic-rps.pdf

4 Table A1.11, Ministry of Justice (2012) Offender Management Caseload Statistics 2011, London: Ministry of Justice

5 Wahidin, A. & Cain, M (Eds.) (2006) *Ageing, crime and society.* Willan Publishing: Devon.

6 http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/prison-and-yoi-inspections/wandsworth/wandsworth-2011.pdf?type=Finjan-Download&slot=0000012D&id=0000092C&location=0A644211

7 http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/prison-and-yoi-inspections/kirklevington-grange/sept-2011-kirklevington-grange.pdf

8 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf

12. Safeguarding has been included within HMIP expectations since January 2012. The expectation specifically states that:

— Prisoners, particularly adults at risk, are provided with a safe and secure environment which protects them from harm and neglect. They receive safe and effective care and support.

13. Safeguarding is an area which the prison service is beginning to address. However, our inspections have found little evidence that prisons are meeting their obligations in this regard. For example, in our most recent inspections of HMP Gloucester[9] and HMP Bullingdon,[10] there were no formal safeguarding procedures or strategy for prisoners at risk.

Whether the treatment of older prisoners complies with equality and human rights legislation

14. HMI Prisons Expectations are based on international human rights standards and norms. Each expectation is underpinned by a set of indicators that inspectors would expect to find if the expectation has been met.

15. The Expectation and indicators for older prisoners are as follows:

Expectation

Older prisoners are treated equitably and according to their individual needs.[11]

Indicators

— Following initial assessment on arrival, older prisoners have a care plan that involves the required range of staff and is reviewed regularly.

— Any special accommodation for older prisoners has been designed based on advice from the NHS, social services and relevant voluntary agencies.

— All staff working with older prisoners know how to recognise the signs of mental health problems and the onset of dementia.

— Older prisoners who are retired or unfit to work are unlocked during the day and provided with access to appropriate and sufficient regime activities.

— Minimum retirement pay is set at a level that is sufficient for those who do not have another source of income.

— Prisoners over retirement age do not have to pay for their TV.

16. Age is a protected characteristic under the Equality Act and the prison service has issued PSI 32/2011 which describes the duties that prison staff have under the Act. Despite this, there is no guidance to staff about working with older people in their care.

17. Since October 2004, prisons have been subject to the Disability Discrimination Act which requires them to take all reasonable steps to ensure that prisoners with disabilities can access services. Prison Service Order 2855, Prisoners with Physical, Sensory and Mental Disabilities, contained a chapter on older prisoners, but it was largely focused on their health and mobility needs in the prison environment, rather than their general welfare. However, this PSO has now been replaced by PSI 32/2011, which does not refer to older prisoners.

18. With regard to female offenders, PSO 4800 contains a section which details how to work with older, female prisoners. It addresses the fact that older women will have different needs to that of other female prisoners, and that these needs should be addressed.

19. The lack of clearly defined responsibilities means that these fundamental rights are not consistently met. At its most basic level, too many older prisoners tell us they do not feel safe and are not treated with respect. In 20011/12 our inspections found:

— About two out of five older prisoners report[12] that they had felt unsafe in the prison at some time and 15% stated they felt unsafe at the time of the inspection.

— One in five older prisoners state they have been victimised by other prisoners.

— 85% of older prisoners state that staff treat them with respect and 84% state they have a member of staff they can turn to with a problem.

[9] http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/prison-and-yoi-inspections/gloucester/gloucester-2012.pdf

[10] http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/prison-and-yoi-inspections/bullingdon/bullingdon-2012.pdf

[11] Relevant human rights standards from HMIP Expectations: Criteria for assessing the treatment of prisoners and conditions in prisons:
Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (principle number 5)
Basic Principles for the Treatment of Prisoners (principal number 2)
Recommendation Rec (2006) 2 of the Committee of Ministers to member states on the European Prison Rules (principle numbers 13, 15.1, 16, 25, 74 and 81.3)
United Nations Principles for Older Persons (principle numbers 4, 5, 11, 12, 14 and 17)
Standard Minimum Rules for the Treatment of Prisoners (principle numbers 6, 24, 25 and 69)

[12] Survey results from prison inspections 2011/12

— We have found examples of older prisoners with mobility problems unable to use the showers and being required to access top bunk beds with associated risks to their health and safety. In some cases, prisoners had been unable to shower for some months and relied on other prisoners for assistance, exposing them to bullying. Some prisons have a formal system of using prisoners acting as carers for older prisoners who have difficulty in caring for all their own needs and provided carers are properly trained and supervised we welcome this.

The effectiveness with which the particular needs of older prisoners including health and social care, are met; and examples of good practice

20. The NSF recommended that a senior nurse has responsibility for older persons care within each area. However, within prison healthcare few establishments have a lead nurse for older prisoners in place. Most prisons have special clinics for older prisoners, but the service provided varies significantly concerning: quality; the age of prisoners targeted; the assessment tools used; and the support services available.

21. There are few discrete services for older prisoners with complex needs who require greater supervision and support. This is compounded by restrictions that are placed on prisoners with mobility issues through, unsuitable prison environments and a reduction in prison inpatient beds.

22. Older prisoners are disadvantaged by limited access to community screening programmes including bowel and Abdominal Aortic Aneurysm (AAA) screening. This is despite the fact that AAA is more likely to be found in males over the age of 65 and bowel screening in the community is specifically offered to those people over the age of 60.

23. Since our original thematic report on older prisoners, we have found that palliative care has generally improved. However, we endorse the concerns raised by the Prison and Probation Ombudsman Annual Report 2011/2012 about the use of restraints on seriously ill, older prisoners, in hospital and his view that they should be able to "die with dignity".

24. 70% of older prisoners report that they are taking medication compared with 44% of the prison population as a whole. Prescribing and medicines administration practice is often weak and this may make older prisoners a target for bullying.

25. Our 2012 annual report noted that although older prisoners in some establishments may be unlocked during the day, there was often little activity available for them. Some prisons provide day centres but this is not typical.

26. Older prisoners may receive retirement "pay" of £2.50 a week. They will often have to pay 50p/week for a television and this leaves very little for other necessities.

27. Although some prison gyms provide sessions for older prisoners, overall older prisoners are significantly less likely to use the gym or take other healthy exercise than other prisoners.

28. Examples of good practice we have found include HMP Leyhill, an open prison holding men serving long sentences, included:

— "The Lobster Pot", a day care centre run by the Resettlement and Care for Older Ex-offenders and Prisoners for the over 50s population, which was an excellent resource. The various activities on offer, which attracted approximately two thirds of over 50s, included training and allowed staff to conduct a dynamic assessment of needs. As a result, the provision was evolving accordingly.

— Many, but not all, older men were located on B wing, and some benefited from the prisoner carers who worked there. There was a shortage of trained and paid prisoner carers, and a number of men helped out on a volunteer basis.

— Retirement pay was £8 a week in contrast with a working wage of around £12.50, so this was comparatively low, but better than we often see. Men over 65 could apply for a free television.

29. In our last inspection of HMP Kingston in 2010, older prisoners made up one third of the prisoner population. Many of these were men who had served long sentences. Work was progressing in this area. For example a popular wallet card system had been introduced for older prisoners, to remind them to attend healthcare appointments and the overarching policy document contained information on the prison's legal obligations for all strands of diversity, with sub-sections on disability, older prisoners and sexual orientation. The closure of HMP Kingston was announced in January 2013.

30. Other examples of good practice include:

— HMP Wakefield—excellent gym and activities available for older prisoners;

— HMP Northumberland—older prisoner meetings; and

— HMP Whatton—excellent palliative care and lead nurse in place.

What environment and prison regime is most appropriate for older prisoners and what barriers there are to achieving this?

31. Older prisoners may have widely variable physical, mental and social needs. However, older prisoners require first what all prisoners require:

- Safety.
- To be treated with respect for their human dignity.
- To be able to be able to take part activity likely to benefit them.
- To be helped to resettle successfully and reduce the risk that they will reoffend.

32. Specifically, older prisoners should have:

- A care plan based on an individual assessment of their needs that is regularly reviewed;
- Reasonable adjustments to the prison's physical environment and regime so that they can access all services and facilities;
- Healthcare equivalent to that offered in the community;
- Activity tailored to their needs and interests—which may often be best provided, at least in part, by a day care facility;
- Income sufficient to maintain a reasonable standard of prison life;
- Access where required and wished to a support group and advocates;
- Help to resettle successfully after release and access relevant entitlements in the community;
- Reintegration support for older prisoners who are being released after long sentences; and
- Support from all staff who are aware of the needs of older prisoners and specialist support where required.

33. The barriers to achieving an effective regime and environment include the lack of a cohesive, national strategy which recognises the individual needs of older prisoners and clearly defines responsibility; a lack training to help staff understand and meet the needs of older prisoners; a limit in the number of appropriate activity places for older prisoners; and a lack of resources in order to overcome environmental challenges.

The effectiveness of training given to prison staff to deal with the particular needs of older prisoners, including mental illness and palliative care

34. With regard to mental health, statistics suggest[13] that over half of all elderly prisoners suffer from a mental disorder. Insufficient staff are being trained in mental health awareness and therefore few have the ability to identify the early onset of mental health problems, including dementia.

35. The Mental Health Foundation has recently published "*Losing track of time*"[14]—research on dementia among the increasing number of older prisoners. This research concentrates on existing evidence as well as new research on managing and treating male offenders with cognitive impairment and dementia. It identifies the challenges and shares examples of good practice used in 14 prisons worldwide, including eight English prisons.

36. Although our inspections have found that palliative care has generally improved, this needs to be consolidated. There is no PSO or service provision relating to it. The study "Dying behind bars: an evaluation of end of life care in prisons in Cumbria and Lancashire"[15] found many prison staff had little experience of caring for prisoners with palliative needs and many specialist community staff have little experience of prisons. The study identified a range of barriers to good end of life care.

37. Some prisoners who have served long sentences and for whom the prison is effectively their home, wish to die there. This requires greater co-ordination between health commissioners and prisons. At HMP Leyhill for instance, inspectors found in 2012 that an excellent palliative care suite had been developed—but the funds had not been identified to run it.

The effectiveness of arrangements for resettlement of older prisoners

38. There are challenges linked to post-release risk management needs, as the late identification of release addresses may hamper effective discharge planning.

39. In our 2008 follow-up report to the older prisoner thematic, we had grave concerns that the social care needs, in particular, of older and disabled prisoners were not planned or provided for, after release. Overall, we found that there was little in the way of specific resettlement help for the older population. We believe that this is still an issue.

[13] HM Chief Inspector of Prisons for England and Wales (2008) Annual Report 2006–07, London: The Stationary Office
[14] http://www.mentalhealth.org.uk/content/site/publications/losing-track-of-time
[15] http://www.lancs.ac.uk/shm/research/ioelc/groups/media/mturner_150410.pdf

40. Many older prisoners will in turn have older visitors—an older spouse for instance. It is particularly important that older prisoners are held close to their homes and that visit facilities are accessible to visitors with mobility difficulties.

Whether a national strategy for the treatment of older prisoners should be established; and if so what it should contain

41. Within the 2008 follow up report to our older prisoners thematic,[16] we called for a NOMS national strategy for older prisoners. NOMS and the Department of Health are assessing the possibility of a national allocations strategy for people with significant care needs.

42. A national strategy should ensure that prisons are able and expected to meet the needs identified above and set out minimum standards.

43. It should set out a clear framework for delivery, define the responsibilities of the prisons and other agencies involved and include a common system for assessing the needs of older prisoners.

March 2013

Written submission from POA, The Professional Trades Union for Prison, Correctional and Secure Psychiatric Workers

Introduction

The number of elderly prisoners has increased within our prisons. Prisoners grow old in prison, having received lengthy sentences while others receive custodial sentences late in life. These prisoner groups have difficult and challenging needs.

Predictions on the size of the prison population are difficult to predict but the policy of the current Government and the effect on the prison regime will do little to improve the conditions of older prisoners.

The Operational Environment

1. The budget cuts reduce staffing levels and impoverish regimes to create a negative impact on safety, decency, purposeful and appropriate activity, rehabilitation and maintenance of family and community ties. These cuts in our opinion impact the aged prison population.

2. Government have pressed ahead with privatisation and prison closures to the detriment of the aging prison population. The new, for old policy in respect of accommodation and facilities, has not addressed the needs of the aging prison population.

3. Prisons are designed to hold and control offenders with little thought for their physical requirements or their health needs.

4. Prisoners with moderate levels of physical infirmity find it difficult, sometimes impossible, to access all areas of the prison.

5. Prisoners with chronic health problems find themselves being accommodated in the prison hospitals as this is the only suitable accommodation (potentially indirect discrimination).

6. Often the programmes and services provided by the prison are inappropriate for aged prisoners with the result that aged prisoners have little, if any access to purposeful activity.

7. Prisoners with disabilities or special needs are often transferred out of their local prison or to a prison which can accommodate their needs. This is a problem that has existed for many years and results in poor family relationships and ties.

8. The POA accepts that many organisations are involved in prisoner's welfare but it is the responsibility of frontline uniformed professional Prison Staff to manage their daily needs.

9. If it is accepted that people are living longer, there has to be a correlation between the numbers of older offenders being convicted of criminal offences which receive custodial sentences.

10. As more prisoners receive longer custodial sentences, more prisoners will age and die in prison.

11. 10 years ago, former Chief Inspector of Prisons Lord Ramsbotham stated that the Prison Service should have "a fully developed strategy for the growing number of elderly prisoners"

12. In 2002 the Department of Health and the Home Office announced that, as from April 2003, the NHS would begin to take responsibility for prison healthcare and hold full operational responsibility for it from 2008.

[16] http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/older_prisoners_thematic-rps.pdf

13. Some of the implications of the proposed changes for older prisoners (as well as the published National Service Framework for Older People) were made explicit in the joint Prison Service and Department of Health "Report of a Working Group on Doctors Working in Prisons", which recommended that:

14. "As part of the health needs assessment process, prisons, health authorities and primary care groups/ trusts review the needs of older prisoners and those with a disability and take steps to ensure that they have access to the same range of professionals and services that are available to these groups in the community. There needs to be a greater emphasis placed on providing both groups with a healthy and suitable regime".

15. Following this report changes were introduced. However further cost cutting have meant that these changes have not proven to be effective whilst the numbers of older prisoners has increased.

16. Do aged prisoners have different needs than younger prisoners and if so, are the current policies and practices fit for purpose?

17. In our opinion many older prisoners are facing not just the effects of incarceration, but the unintended consequences that institutions are unable to provide for their particular needs. (Indirect Discrimination.)

General Health Issues

Health problems from mild aches and pains to the most devastating illnesses do not go away when offenders are sent to prison. Prisoners may be loath to admit to illnesses for fear of being bullied and staff may not have the time or skills to identify the problem.

Alzheimer's & Dementia
Alzheimer's disease is the most common form of dementia. There are other types of dementias, memory loss and impaired cognitive function that impact seniors.

Parkinson's disease
Parkinson's disease is a chronic, neurological disorder that affects nerve cells in the part of the brain that controls muscle movement.

Incontinence
Incontinence, or loss of bladder control, can happen for a number of reasons. Whether it's temporary or chronic, it's unpleasant. It also can lead to emotional distress.

Cancer
Cancer is a group of more than 100 diseases in which abnormal cells grow out of control, thereby invading other parts of the body. There were more than 1.5 million new cases of cancer reported every year.

Heart Disease
Heart disease—whether it's a heart attack, stroke, cardiac arrest, high blood pressure, peripheral artery disease, or another cardiovascular condition.

Arthritis
Arthritis is a painful condition that can strike the spine, neck, back, shoulder, hands and wrists, hip, knee, ankle, and feet. It can be immobilizing, and it comes in many forms.

Vision & Eye Diseases
Macular degeneration, cataracts, glaucoma, presbyopia, and retinal disorders are just some eye diseases that can reduce a senior's ability to see well.

Diabetes
Having high blood glucose levels is the hallmark of diabetes, a group of diseases that affects the body's ability to produce or use insulin correctly.

Sleep Disorders
Sleep disorders—whether insomnia, sleep apnoea, or movement disorders—all can rob elderly people of needed sleep. Disruption in sleep patterns can lead to more problems than just making the elderly feel more fatigued.

Depression
Depression is a serious medical illness. It's more than just feeling "down in the dumps" or "blue" for a few days. It can be mild or so major that it's disabling and it can also be hard to recognize.

Hearing Loss
It is accepted that between the ages of 65 and 74 hearing problems occur. That statistic increases with age. Yet only one in five people who could benefit from a hearing aid actually wears one how this compares in prison is not known.

Osteoporosis
Osteoporosis is a condition that causes bones to break more easily and take longer to heal. As a result, even minor falls can land elderly people in hospital.

Lung Disease
Lung diseases can diminish an elderly persons ability to breathe well. While many types of lung problems can be treated or prevented, they can be serious, with major complications.

The POA accepts that the vast majority of these illnesses would be picked up by the Healthcare profession in the community. Some may not have been in prison and if left untreated they can lead to violence, bullying and or serious acts of self-harm or self-inflicted deaths as older prisoners come to terms with prison life and change.

The cost of looking after an ageing prison population as a result of associated health problems needs to be considered as part of any proposals.

Physical Barriers

A physical barrier is when a person can't access the care they want or need because of a physical problem like a walking difficulty or a wheelchair access. In prisons these are often exacerbated due to the design of the building and structure of the regime.

A simple activity like collecting a meal in some prisons can be extremely difficult for an elderly prisoner. Some elderly prisoners may need the use of a walking stick so simple tasks become difficult and pride often prevents help for other prisoners no matter how well intentioned.

The vast majority of elderly prisoners are located on the lower landings to assist them in their daily movements but due to the pace of the regime they can often find themselves in the way or holding up the routine which often causes them to lose self-esteem for example.

Conclusion

The care and wellbeing of the ageing prison population is a serious issue that if left unaddressed will create long term operational difficulties for the service. We currently have female, juvenile and young offender and a high security estate but no estate to deal with the older population perhaps this is something that should be considered as part of the process.

March 2013

Written submission from the Prisons and Probation Ombudsman

Background

1. When I appeared before the Justice Select Committee for confirmation of my appointment, I indicated that a key part of my vision for my new office was increasingly to identify and disseminate lessons from investigations which deserved to be learned by the services in remit. This occurs routinely in individual investigations, where recommendations may be made for improvement, but it should also be possible to contribute more generally to improvement in custody by identifying broader lessons from a number of cases. To this end, I have created a new series of learning lessons bulletins, as well as continuing to produce thematic studies. Some of these touch on the Committee's interest in exploring the effectiveness with which the particular needs of older prisoners are met and good practice.

2. I am conscious that the Committee has guidelines on the submission of written evidence which are transgressed by attaching documents which together constitute more than 3000 words. I therefore briefly identify key issues below and leave it to the Committee as to whether the full documents (published in PDF format but provided here in Word version) are required for reference.

Learning lessons about older prisoners from death in custody investigations

3. The majority of deaths investigated by my office are from natural causes. Last year we investigated 142 deaths from natural causes (a rise of 16% on the year before),[17] of whom 132 were serving prisoners, three were immigration detainees and seven were living in approved premises. Older prisoners made up a high proportion of these deaths, with nearly half (70) having been aged over 60.

4. These deaths reflect an ageing prison population; a changing demographic linked to conviction of offenders later in life and increasing sentence length. While prisoners of all ages can suffer serious health issues, health problems increase with age. It is remarkable that, although still a small proportion (4%) of the total prison population, those over 60 are now the fastest growing age group in custody. The number of sentenced prisoners aged 60 and over more than doubled over the past ten years, from 1,376 in 2002 to 3,333 in 2012.[18] This poses a significant challenge to a prison system originally more geared to a younger population.

5. A brief description is provided below of findings from three recent publications which present collective learning from investigations into deaths in custody undertaken by my office and which may be of interest to

[17] Prisons and Probation Ombudsman Annual Report 2011–12, statistical tables, p45
[18] Table A1.11, Ministry of Justice (2012) Offender Management Caseload Statistics 2011, London, Ministry of Justice

the Committee. In summary, the reports suggest some commendable progress in the treatment of older prisoners by the Prison Service, in conjunction with the department of Health and various charities. Thus at a time of competing pressures, much has been done to improve end of life care for many prisoners dying in prison. However, the improvements are not uniform and in some areas, for example the use of restraints on terminally ill prisoners, my investigations too often found that the Prison Service got the balance wrong between care and decency.

— *Learning from PPO investigations: Natural cause deaths in prison custody 2007–2010 (March 2012).* This thematic report provides summary data on 402 deaths during this period. The report looked at equivalence of care with the community (as judged by the independent clinical reviewers' commissioned to contribute to my investigations). Equivalence of care was found to increase with age, with nearly 85% of those who died aged over 55 being judged to have had care equivalent to that they might have expected in the community, compared to only 72% of those under 55. Those whose deaths were reasonably foreseeable, either due to a terminal illness or multiple chronic conditions and old age, were also more likely to be judged as having received equivalent care.

— *Learning Lessons Bulletin 2: Use of restraints in fatal incidents (February 2013).* This short bulletin noted that the care of increasing numbers of seriously ill and dying prisoners poses a growing challenge for the Prison Service, particularly as the population ages. Improvements, for example better palliative care were noted but investigations too frequently identified inappropriate use of restraints on seriously ill prisoners being taken to hospital or hospice for treatment. The principal responsibility of the Prison Service is to protect the public but too many prisons struggled to balance appropriately security with humane treatment for the increasing numbers of prisoners dying in their care. Suggested lessons included the need to adjust risk assessments to take account of the current health and mobility of prisoners, and the need to consider medical opinion.

— *Learning from PPO investigations: End of life care (publication due 27 March 2013).* Currently in draft form, this thematic report presents a review of 214 fatal incident investigations into foreseeable natural cause deaths, of which 58% were of prisoners aged over 60. Commendably, the majority of prisoners (85%) received care which was assessed by our clinical reviewers as being equivalent to what they might have expected in the community, but there was still a good deal of variation between prisons. For example, a third of these prisoners did not have a palliative care plan in place. Learning points for prisons focussed on full implementation of end of life care plans, better involvement of prisoners' families and, once again, avoiding inappropriate use of restraints.

I and my office are at the Committee's disposal should you require further information or clarification.

March 2013

Written submission from the Offender Health Research Network

SUMMARY

— Senior *et al* (2012), conducted a large scale research study regarding health and social care services for older adult men in prison.

— **This project was commissioned by the NIHR Service Delivery and Organisation (NIHR SDO) programme under the management of the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. From January 2012, the NIHR SDO programme merged with the NIHR Health Services Research (NIHR HSR) programme to establish the new NIHR Health Services and Delivery Research (NIHR HS&DR) programme. The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR HS&DR programme, NIHR, NHS or the Department of Health.**

— The research was funded by the National Institute for Health Research and took place over three and a half years, concluding August 2012.

— The research programme was a mixed-methods study divided into the following four parts.

1. A study of all prisons in England and Wales housing adult men, establishing the current availability and degree of integration of health and social care services for older adults.
2. Establishing the health and social care needs of older men entering prison, including their experiences of reception into custody.
3. The development, implementation and evaluation of an intervention to identify and manage the health, social care and custodial needs of older men entering prison.
4. Exploring the health and social care needs of older men released from prison into the community.

— Key findings pertinent to this inquiry into older prisoners include:

  — A lack of accountability and clarity regarding the responsibility for addressing the social care needs of older prisoners;

— That, on entry into prison, older prisoners' highest proportions of unmet needs were in the domains of information about their care and treatment, psychological distress and daytime activities;

— The Older prisoner Health and Social Care Assessment and Plan (OHSCAP) was developed through action learning as part of the research. It is a structured approach for identifying and managing older prisoners' needs. We concluded it was possible for a Prison Officer to deliver the intervention successfully. It was considered to be acceptable, feasible and of value to staff and prisoners; and

— Release planning for older prisoners is generally inadequate.

Whether responsibilities for the mental and physical health and social care of older prisoners are clearly defined.

— Interviews were held with 32 staff members including prison, healthcare and external agency staff (such as community-based social care services and specialist older age organisations).

— The findings identified a lack of integration between health and social care services due to ambiguity regarding responsibility for meeting older prisoners' social care needs.

— A prominent theme that emerged was the ambiguity staff felt around whom, or which disciplines/agencies were, properly responsible for providing social care to prisoners. Problems around the integration between the prison and community-based services were a recurring theme and were, in the majority of cases, felt to be non-existent. Even when integration existed, relationships between prisons and social services were generally considered to be strained. One interviewee described how prison staff often considered the social care of older prisoners to be the responsibility of other prisoners rather than staff and therefore other prisoners would often be left to assist older prisoners with their social care needs without adequate training to undertake such tasks.

— Geographical limitations were highlighted as a significant barrier to effective integrative working. Many prisoners, particularly those serving long sentences, do not reside in prisons in their home area. Additionally, people are often transferred routinely between a number of establishments during their sentence and ongoing care from outside, or prison-based, agencies is often considered to be insufficient a priority to keep an older person in one particular establishment. This can create tension between the prison and local social care services. A Social Worker in the mental health in-reach team illustrated this by detailing an experience of contacting a local authority on behalf of a prisoner, outside of the area in which their current prison was situated. He described a laborious process of trying to get staff in the person's home local authority area to accept that the prisoner was originally from their area. The local authority instead stated that the prisoner should be released to the area in which the prison was located, an area to which the prisoner had no home or family ties to help with successful community reintegration.

The effectiveness with which the particular needs of older prisoners including health and social care, are met; and examples of good practice.

— Our study assessed the unmet needs of recently incarcerated older prisoners, as well as capturing their experiences of being received into prison custody. Results from the Camberwell Assessment of Need—Short Forensic Version (CANFOR-S, Thomas et al., 2003)showed that the highest proportions of unmet needs were in the domains of information about condition and treatment (38%); psychological distress (34%); daytime activities (29%); benefits (28%) and physical health (21%). Full results are given in table in Appendix 1.

— Analysis of Geriatric Depression Scale (GDS; Sheikh & Yesavage, 1986) found that nearly one third of our sample (31.4%;n=27) reached the cut-off score for mild depression and nearly one quarter (23.3%; n = 20) reached the cut-off for severe depression.

— Only eight (17%) of those showing signs of depression were receiving anti-depressant medication and five (12%) had contact with a Mental Health Nurse during their initial four weeks of custody.

1. *What environment and prison regime is most appropriate for older prisoners and what barriers there are to achieving this?*

N/A

2. *The effectiveness of training given to prison staff to deal with the particular needs of older prisoners, including mental illness and palliative care.*

— Example of good practice—The Older Prisoner Health and Social Care Assessment and Plan (OHSCAP) was developed by an Action Learning Group including older prisoners, healthcare staff and prison staff. The group decided that the Older Prisoner Lead (OPL), usually a prison officer, was the most appropriate person to deliver the OHSCAP. The OPL successfully delivered the OHSCAP and older prisoners found him to be helpful, professional and felt at ease talking to him. A copy of the OHSCAP is included in appendix 2.

3. *The role of the voluntary and community sector and private sector in the provision of care for older people in leaving prison.*

N/A

4. *The effectiveness of arrangements for resettlement of older prisoners.*

— Qualitative interviews were carried out with prisoners in custody who had four weeks left to serve, with follow-up interviews in the community within four weeks of release. Sixty two prisoners were interviewed in prison and 45 (73%) were successfully followed up on release (73%).

— Release planning for older prisoners was frequently non-existent. When asked about the plans for release, prior to their discharge, the majority of prisoners simply stated that no plans had been made. It was their perception that their release was not being planned at all. They described that this caused high level of anxiety in the months, weeks and days prior to release.

— A number of participants were unaware of where they were going to be living until a few days prior to their discharge from prison. A lack of information about where older prisoners would be housed was a key contributor to these high levels of anxiety and provided a key barrier for the older prisoner to plan their release. In particular, older prisoners were particularly anxious about the prospect of residing in probation approved premises. The provision of pre-release courses was *ad hoc* and where such courses were provided, information was not tailored to the needs of older prisoners. There was a perception that there had been minimal or no contact with Probation Workers and Offender Managers in preparation for release.

— Once released, anxiety levels were generally reduced, largely as a result of people being generally satisfied with their placement in approved premises, despite their foreboding about it whilst still in custody. Those in approved premises tended to report that their immediate health and social care needs were largely well met. Those residing in approved premises generally considered themselves to be in a transitional period, where they had not been fully released into the community.

— Those who were residing in probation approved premises had fewer unmet needs on release than those who were not. Such participants were more likely to perceive their health and social care needs to be unmet on release, even though they did not always anticipate that they would require support on release. Their unmet needs varied but included a lack of support with finance and employment, and being inappropriately housed.

5. *Whether the treatment of older prisoners complies with equality and human rights legislation.*

N/A

6. *Whether a national strategy for the treatment of older prisoners should be established; and if so what it should contain.*

The evidence from the current study suggests the following:

1. Fundamental adaptations to prison buildings are still required to allow older prisoners with mobility difficulties physical access to services and facilities fully in accordance with The Equality Act.
2. There has been an increase in the number of assigned Older Prisoner Leads in healthcare departments, however they are still not present in all establishments and a large proportion are not active in their role. Each prison should identify an Older Prisoner Lead within their healthcare department who should lead on the development of specialist services such as older prisoner/buddy schemes and designated older adult clinics.
3. A large proportion of establishments are failing to adhere to the Department of Health's recommendation that they should have an older prisoner policy in place. Each establishment should develop such a policy.
4. Establishments and their partners are, in the main, failing to meet the Department of Health's recommendation that there should be effective inter-agency co-operation between healthcare

and social services. An identified social care lead may well assist with these difficulties and help to actively support and address older prisoners' social care needs.

5. The ambiguity regarding the responsibility of social care for older prisoners requires clarification to improve integrative working.
6. An increase in face-to-face networking opportunities would improve effective integrative working between health and social care staff.
7. It would be beneficial to house older prisoners in close proximity to their planned release location in order to improve the co-ordination of their care.
8. Comprehensive local agreements between prisons and social services should ensure that local social services effectively coordinate care for all prisoners.
9. The Department of Health's recommendation for providing an older person specific health and social care assessment on entry is largely unmet. Evidence suggests that such specialised assessments are required because older prisoners have more complex health and social care needs than their younger counterparts and those of a similar age living in the community.
10. The tool developed in our study, the OHSCAP, is feasible, acceptable and of value to older prisoners and staff.
11. It would be beneficial for Older prisoner Leads to receive training in the use of the OHSCAP and case management.
12. Release planning for older prisoners requires improvement and needs to start earlier in a person's sentence than it does at present. Furthermore, older prisoners and healthcare, social care and prison staff do not presently routinely work co-operatively to plan discharge, causing high levels of anxiety for older prisoners.
13. The Department of Health's recommendation that prisons provide pre-release courses specifically designed for older prisoners is often not adhered to. Each establishment should regularly provide such courses.

March 2013

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APPENDIX 1

TABLE 1

RESULTS FROM THE CAMBERWELL ASSESSMENT OF NEED—SHORT FORENSIC VERSION

Need on entry into prison (CANFOR-S domains)	*Cases analysed*	*older prisoner with unme need n (%)*
Information about condition and treatment	100	38 (38%)
Psychological distress	100	34 (34%)
Daytime activities	100	29 (29%)
Benefits	100	28 (28%)
Food	100	22 (22%)
Physical health	100	21 (21%)
Telephone	100	13 (13%)
Money	100	13 (13%)
Company	100	10 (10%)
Accommodation*	57	9 (16%)
Looking after the living environment	100	8 (8%)
Treatment	100	8 (8%)
Alcohol	100	7 (7%)
Self care	100	6 (6%)
Intimate relationships	100	6 (6%)
Basic education	100	5 (5%)
Transport*	57	5 (9%)
Childcare*	4	0 (0%)
Psychotic symptoms	100	2 (2%)
Safety to self	100	2 (2%)

Need on entry into prison (CANFOR-S domains)	*Cases analysed*	*older prisoner with unme need n (%)*
Sexual expression	100	1 (1%)
Sexual offending*	74	1 (1%)
Drugs	100	0 (0%)
Arson*	2	0 (0%)

** Denotes item can be scored as "not applicable"*

APPENDIX 2

OLDER PRISONER HEALTH AND SOCIAL CARE ASSESSMENT AND PLAN (OHSCAP)

General Information

— This assessment tool is divided into three areas: wellbeing, social care and discharge from prison. It revisits information that may already have been provided on initial reception, and identifies new information that has come to light following a few days in custody. It then explores any issues relevant to ensuring appropriate discharge from prison.

— It is to be completed 7–10 days after the prisoner has arrived in the prison.

— Ideally it will be completed by both health care and discipline staff together, jointly interviewing the prisoner. This is provided he is happy to discuss his health issues in front of the discipline officer. However, it may be more appropriate for the discipline officer to take the lead and refer to health care if necessary.

— The assessment will be reviewed at a time deemed appropriate by staff completing it, and the prisoner.

— A care plan must be completed by the staff conducting the assessment, and agreed with the prisoner. The prisoner may retain a copy of the care plan if they want to.

Social Assessment

The aim of this part of the assessment is to discuss any issues with the prisoner that might be affecting his ability to settle into prison life and feel safe. The questions are divided into three sections: relationships; activities and mobility. There is space in the assessment to record discussion on any other areas that might be important to the prisoner.

Wellbeing Assessment

This part of the assessment revisits the information gathered during medical reception a week earlier to see if there have been any changes, and to identify if the prisoner requires further health/wellbeing assessment following the first week of settling into custody.

Discharge from Prison

This part of the assessment explores the issues that require addressing prior to the prisoner being discharged from prison.

SECTION ONE: SOCIAL ASSESSMENT

Name	*Date of Birth*
Age	NOMS Number

A: Relationships

Ask the person if they have been able to maintain their social and family relationships whilst they have been in prison. Is anyone looking after their finances/benefits etc? How are they getting along with other prisoners? Do they feel safe?

B: Activities

What is the prisoner doing with their time? What are their interests/hobbies? Are they aware of what is available to them eg gym, over 60's club, library? Do they want to work? Are they going out on exercise? If not, why not?

C: Mobility

Is the prisoner managing to get around safely? Can they collect their own meals; get in/out of bed, get to/from their cell to association, and in/out of shower. Can they walk to visits/healthcare/treatment room etc?

SECTION TWO: WELLBEING ASSESSMENT

D. Emotional wellbeing

Is the prisoner coping OK with being in prison? How are they feeling in general? Are they feeling supported? Are they getting on with other prisoners—feeling safe? Are they sleeping? Do they have any concerns?

E. Physical wellbeing

Are there any physical problems that have arisen since first reception in to prison? Can they think of anything they might have forgotten to mention when they first arrived? For example, have they got their reading glasses/ contact lens solution etc? Does the prisoner know how to access health care? Are they able to attend to their own personal hygiene needs effectively?

F. Medications and treatment

Does the prisoner take any medication? If so, have they been getting it at the right times? Are there any problems with getting their medication eg ability to attend treatment room, pressured into giving it to other prisoners?

G. Any other concerns that have not already been mentioned?

SECTION 3: DISCHARGE FROM PRISON

H. Discharge from Prison

When is the person being discharged from prison? Where do they plan to go? Will they be welcome there? Do they have finances in place to support themselves? Are there any health care/social care needs that need to be considered?

Healthcare staff (sign) (IF PRESENT)	(Print Name)	Date
Discipline staff (sign)	(Print Name)	Date
Prisoner (sign)	(Print Name)	Date

Care Plan

TO BE COMPLETED IN CONJUNCTION WITH PRISONER

Number	*Issue raised from assessment*	*Aim of action*	*Action (including by whom and when)*	*Date to be reviewed and rationale*	*Status of action*
1					
2					
3					
4					
5					

Review

Date

Reviewer(s):

Number	*Progress since last review*	*Action planned*	*Next review with rationale*
1			
2			
3			
4			

Review

Date:

Reviewer(s):

Number	*Progress since last review*	*Action planned*	*Next review with rationale*

Written submission from RECOOP

RECOOP is an independent charity delivering support services and resettlement programmes for older prisoners in the South West of England. We also carry out capacity-building work on behalf of NOMS with prisons, probation trusts and third sector organisations across England and Wales to improve the range and quality of interventions, support and services available for older offenders and ex-offenders.

SUMMARY OF RECOMMENDATIONS:

- The threshold for an "older prisoner" to be lowered to 50, due to the more rapid onset of physical symptoms of aging amongst prisoners than in general population;
- Older prisoners' forums to be established in all prisons;
- Older prisoners' accommodation units/wings to be established where possible;
- Age-relevant resettlement programmes and support services to be made available in all prisons, particularly for retired prisoners who do not take part in education or work. In many cases these could be delivered by prisoners themselves using resources available on the "virtual campus" (online prison learning environment);
- "Buddying" to be established in prisons, where older and disabled prisoners with mobility issues are supported by another prisoner to carry out every-day tasks;
- Older prisoners to complete a tailored resettlement course for older people prior to release (eg RECOOP/Media For Development's "Getting ready to go" course) and to develop personal release plans with the support of a dedicated officer;
- Retirement for prisoners to be made optional, and retired prisoners to have continued access to work and education opportunities;
- Legislation put in place so that older prisoners are not released to "no fixed abode";
- Through-the-gate mentoring support available for older offenders on release;
- A national strategy for older offenders to be developed.

DEFINITION OF "OLDER PRISONERS"

1. "Older prisoners" should be defined as prisoners over the age of 50, not 60 as set out in the terms of the Inquiry. This is due to the evidence that, in prison, older people can have health symptoms of people ten years older in the community. In "Doing Time: Good practice with older people in prison—2010", the Prison Reform Trust defines "older" people as anyone aged 50 or over for the following reasons:

- Some older prisoners will have a physical health status of 10 years older than their contemporaries in the community. This can be due to a previous chaotic lifestyle, sometimes involving addictions and/or homelessness.
- Fifty is used in NHS healthcare and services for healthy ageing start at this age.
- Age UK and organisations working with older people start their services at 50.

2. The former Offender Health Commissioner for Devon said in her 2011–2012 health needs assessment: "An 'older prisoner' is deemed to be aged over 50 to account for the potential impact of [his] lifestyle choices on his physical health… Clearly not all individuals older than 50 in the prisons will have complex and complicated health and social care needs but there will be many who do. Chronic and long-standing conditions will be greater amongst this age group."

Whether responsibilities for the mental and physical health and social care of older prisoners are clearly defined

3. Following our engagement with over 60 prisons across the estate [see Appendix 1], it would appear that most are relatively happy with the standard of healthcare for older prisoners but do not delve too deeply into

what is actually in place. This suggests responsibility sits with prison healthcare services, who will respond to physical health issues but mental well-being and social care are a "grey" area.

4. An example: a prisoner needed special footwear due to his diabetes, but no-one was sure who should take responsibility for paying. It took nine months to resolve with the prison finally buying the item, but the prisoner was unable to engage in regime activities during this time as his mobility was restricted. The prison still feels unclear as to who should have taken responsibility.

5. Mental health is difficult to measure though there are concerns around under-diagnosis due to difficulties in identification. For example, older people suffering from depression may be perceived as just being "quiet" [No Problem—Old and Quiet, HMIP 2004], and their lack of motivation will not be challenged as there is often little expectation of them to do anything anyway.

6. Dementia sufferers often function well in a structured environment. A prison regime might increase the chance of symptoms going undetected for longer. "The prevalence of dementia among older prisoners remains largely undetermined. Combining rates in the community with the theory of accelerated ageing in prison would suggest it affects approximately 5% of detainees over 55." [Losing track of time: Dementia and the aging prison population, Mental Health Foundation, 2012.] However, official diagnosis in prisoners is thought to be much lower than this.

7. Social care tends to be the biggest emerging issue reported by prisons. Even when prisons have developed links with their local Social Services and have arranged for carers to visit prisoners, the Local Authority uses agency staff and the procedures for getting them security cleared are unworkable for most prisons. Meeting the needs of prisoners with social care issues tends to be based on goodwill (predominantly from fellow prisoners), which can work well with prisoners collecting meals for each other and helping to clean cells etc. but is more complex when, for example, a prisoner develops continence issues or is unable to dress themselves.

8. There are reported cases of prisoners being permanently located in 24 hour healthcare facilities due to social care needs. This is a far from satisfactory solution for all concerned and raises the question of how long this system will be viable as the number of older prisoners continues to increase.

The effectiveness with which the particular needs of older prisoners including health and social care, are met; and examples of good practice

9. No-one would challenge the benefits of mental and physical stimulation for older people and for them to engage in age-specific activities to benefit both mental and physical health, yet prisons seem to focus on responding to immediate age-related problems as they emerge such as depression, early-onset dementia and poor levels of fitness, rather than considering preventative measures.

10. Examples of good practice in RECOOP's work in prisons in the South West, and in work undertaken by prisons we support through our capacity building work:

- **RECOOP** runs a mental wellbeing programme in three Devon prisons. This involves weekly "brain gyms" for older prisoners and group sessions of Shibashi Qi Gong, an adapted form of Tai Chi for older people and people with mobility issues.
- **RECOOP** supports the delivery of older prisoners' forums. These promote skills and confidence to help older prisoners cope better on release and are recognised in prison governance structures as a legitimate means by which prisoners' concerns can be addressed.
- **RECOOP** works with older prisoners at HMP Leyhill to produce personal release plans covering appropriate support services and arrangements for key transitional stages, including preparing for release and/or preparing for end-of-life in custody.
- **RECOOP** works with older women prisoners at HMP Eastwood Park to provide a quiet space and relevant activities for the older women twice a week. Work here is shorter term and based around individual activities as the average length of stay is short (c.6 weeks). Equality Officer: "For the first time in my prison career I have witnessed this unique group of prisoners happily serving their sentences whereas in the past they would be quite vulnerable and of a concern to staff."
- **HMP Stafford** allows older prisoners not engaged in education or work to meet up during the core day in a portacabin, but they were struggling to fill the time productively. They've recently begun making breakfast packs, which has had a significant positive impact on the men. One representative reported that this simple activity had provided those taking part with a sense of worth, achievement and usefulness alongside fostering a sense of camaraderie in working towards a common goal. HMP Stafford prioritise their work with older prisoners due to the high population they accommodate (18.6% of the population are over 50 yrs old. National average is 11.5%—NOMS 2012)
- **HMP Whatton** contracts in Age UK services to run a support group for older prisoners where age-specific activities similar to those delivered by RECOOP are undertaken. Sustainability is currently under threat due to cost. HMP Whatton has demonstrated a commitment to palliative care services, again due to the relatively high numbers of older prisoners there (91 over 60 and 55 over 70 on 30.9.12).

What environment and prison regime is most appropriate for older prisoners and what barriers there are to achieving this?

11. Establishing dedicated older prisoner accommodation units or wings:

Advantages

- Older prisoners feel safer amongst their peers, reducing stress and anxiety.
- It would be a quieter and more peaceful environment free from loud music, often reported to be a source of anxiety for older people.
- Older prisoners are more likely to engage in age-specific activities if they are carried out on their wing and they don't have to negotiate free flow or route movement restrictions in order to attend. Particularly pertinent for those with sight, hearing, mobility issues.
- Older prisoners can instigate activities during association periods. Forums [see para. 10] could meet and prisoner volunteer "peer-educators" could print RECOOP session plans from the virtual campus to deliver relevant activities with their peers on the unit, increasing purposeful activity and out of cell time.
- The unit could be adapted for disabled people, reducing the need to adapt all areas of the prison.
- Buddying schemes could be developed where physically fit prisoners assist disabled prisoners with simple tasks such as collecting meals and cleaning cells.
- May require less staffing as older prisoners are generally more settled and do not require as much supervision or intervention as their younger counterparts. It may be appropriate for the unit to be an enhanced prisoner unit only.
- Healthcare can target certain resources to one single area.

Disadvantages

- Some older prisoners may not wish to live there or may have concerns about perceptions relating to offence type. Residence on the unit could be optional. This may mean, however, that prisoners who chose not to live there would miss out on attending relevant, age-specific activities. In such cases effort would still need to be made to encourage and enable prisoners not living on the unit to attend.
- Young prisoners may feel it is unfair for older prisoners to have a dedicated unit.
- Older prisoners are often seen to provide a valuable "steadying" influence on the younger population, and prisons may be reluctant to risk losing this. However, if older prisoners are not forced to retire in a prison and have continued access education, then they will continue to exert this influence on a regular basis.

12. There are very few disadvantages to dedicated older prisoners' accommodation areas. Prison policies on retirement age and access to education should be considered, and situations where older prisoners are forced to retire and are no longer allowed access to education should be addressed.

The effectiveness of training given to prison staff to deal with the particular needs of older prisoners, including mental illness and palliative care

13. The only training in this area that we are aware of is that which we (RECOOP) have sourced and delivered ourselves for the prisons we work with in the South West. Our service delivery team in prisons has arranged ad hoc training for prison staff in issues such as Mental Health and Dementia awareness. Although course feedback was positive, the longer-term effectiveness has not been measured.

14. Feedback from older prisoners we work with: Officers need further specialist training in "spotting the signs" of mental and physical health needs in older prisoners.

15. In our experience, key training areas for consideration are:

- supporting people with serious health decline and at end of life;
- recognising symptoms of age-related illnesses;
- planning resettlement for older people; and
- recognising that many older prisoners will not be expected or expecting to access training or employment on release, and building awareness and confidence around accessing other appropriate positive activities on release.

The role of the voluntary and community sector (VCS) and private sector in the provision of care for older people in leaving prison

16. There are many community resources for prison leavers, particularly services targeting young people. It's generally accepted that young people have specific needs and services have been developed in the community to meet those needs, (eg young people's accommodation and training facilities). We have, however, identified no

community resources aiming to meet the needs of older people leaving prison, although it could be argued that older people are in more need of specialist support due to the complex issues they face, such as:

- Deteriorating health, age-related illnesses and feelings of vulnerability.
- Issues around institutionalisation where a lengthy prison term has been served.
- Lack of social networks and support structures.
- Retirement.
- Potential exclusion from activities for older people due to offence type.
- Difficulties accessing sheltered/supported housing due to offence type.
- Older people do not tend to embrace change as readily as younger people.
- Increased social isolation due to being a) an older person and b) an ex prisoner.

17. Providers of ex-offender mentoring services tend to focus on training and employment opportunities. These are often not relevant to older people.

18. The VCS and private sector specialising in services for older people are in a favourable place to develop services to meet the needs of older prisoners on release, but there appears to be a reluctance due to lack of funding and concerns regarding risk factors around working with offenders.

19. A housing provider which provides ex-offender accommodation at projects in and around Birmingham is currently exploring the possibility of setting up an older ex-offender supported housing project. They report that when they've worked with older offenders released to their generic projects for adults in the past they've recognised the need to tailor their approach to meet the needs of the older person. The biggest factor reported was the slower pace at which older people adapt to life in the community and a general reluctance to engage in activities or even leave the building during the first few weeks. They also report that older ex-offenders often need more staff support initially, but that long-term results were very positive.

20. There are useful services in most communities—walking groups, coffee mornings, befriending services—and most facilitating agencies have no objection to ex-offenders accessing them. However, there seems to be an issue in getting the offender to the point where they feel motivated, confident and willing to go along.

The effectiveness of arrangements for resettlement of older prisoners

21. Davies, The reintegration of elderly prisoners, 2011: "Older inmates disproportionately struggle with resettlement as a result of distinct psychological adjustments they have made in prison, a reduced support network in the community and an increased likelihood of health and mobility concerns. These problems are exacerbated by a system oriented on a stereotypical understanding of the young male criminal. In England and Wales, this has restricted the usefulness of prison programmes and activities for older prisoners who are less likely to re-offend and who are less likely to be a threat to society upon release. With the prioritisation of reducing re-offending and protecting the public, the National Offender Management Strategy (NOMS) fundamentally conflicts with the characteristics of elderly prisoners and fails to consider their re-integrative needs"

22. In the 60+ prisons we work (Appendix A) with, little specific resettlement support s being provided for older prisoners. Funded to develop collaborative working between the 3rd sector and prisons/probation services, we are in an ideal position to comment on the void outside the prison gate in terms of services or support for older offenders. There is a strong need to develop specialist pre- and post-release services for older ex-offenders. There is a lack of communication and joint working in the transition for older prisoners from prison to the community; statutory agencies appear to work mainly in isolation, only communicating effectively when managing the transfer of an offender's risk between services. Care/resettlement plans or assessments with a social care element would provide a good starting point to prepare for an older offender's transition into the community. Older offenders may leave prison with a licence requirement to have a confirmed address or place within an Approved Premises by a set time, when they are on walking sticks or struggling with mobility problems and thus will not be able to do this as quickly as a younger prisoner. Furthermore, the practicalities of achieving this are more difficult for someone who has been incarcerated for a long period of time.

23. Approved Premises (APs) are the most likely destination for long-term prisoners, who've effectively grown old in prison, but they report a lack of information on the health and social care needs of older offenders. There should be an assessment prior to release, to ensure a smooth transition into the community. There is a free older prisoners' resettlement assessment tool available on the RECOOP website, though prison resettlement staff have demonstrated a reluctance to use it due to the additional workload it may create. There is also confusion regarding whose responsibility it is in the prison to instigate Social Services support.

24. Not all older offenders will face accommodation issues on release, but many long-term prisoners will have lost contact with friends and family. For many, hostel accommodation is not appropriate as they are often challenging environments where older people are particularly vulnerable and are seen as "easy targets" Most hostel staff do not have the required knowledge or expertise to effectively support older people. Hostel accommodation can only be avoided if an older prisoner has significant health and/or social care needs, or has

served an extended period in custody (four years or more); here, there is a duty on the Local Authority to source housing in accordance with the Homelessness Act 2002.

25. Successful resettlement is a significant factor in reducing re-offending, though resources are minimal in most prisons and there are significant difficulties in sourcing appropriate accommodation for prisoners on release. Whilst age-related needs are recognised by most Local Authority Supporting People budget holders for young offenders, the same does not apply for older offenders. Ideally, resettlement planning for older prisoners should include:

- Courses where older prisoners can mentally prepare for release such as RECOOP/Media For Development's "Getting ready to go".
- Thorough needs assessment and further assessment by Social Services if necessary to ensure that support services are in place at the point of release.
- Financial planning with pensions being applied for prior to release.
- Through-the-gate mentoring support delivered by agencies that understand the needs of older offenders and are specialists in age-related issues.

26. Older prisoners are frequently released to "no fixed abode" (NFA). This effectively "sets them up to fail"—any positive work carried out pre-release (eg survival cooking in a hostel) is redundant. [NB Welsh system has legislation in place preventing prisoners being released to NFA.] There is little to no pre-release planning for individuals, eg a wheelchair user might be released without a wheelchair, with totally inadequate clothing for the time of year, with no information about what support is available on the other side and no guide to being homeless.

27. There is a significant danger that an older offender may perceive that their basic needs (access to healthcare, gym, meals provided, laundry done, friendships etc.) were met in prison and that these needs are no longer met when they are released, resulting in a desire to return to prison where life is easier and safer. This is why specialist support after release is so important with this age group.

28. Better preparation for release should include: benefits and pensions organised beforehand so they are accessible within a week of being released; photo ID arranged before release; bank/post office account in place; housing address confirmed so no-one is released to NFA; practical and social skills release courses; volunteering placements arranged (for prisoners on ROTL before release where possible); through-the-gate mentors to support resettlement process; more opportunities for community sentencing for older prisoners who do not pose a serious risk to society. Offender accommodation management: "It would be enormously helpful if offenders were registered with a GP and dentist prior to release"; "Not having benefits set up prior to release can mean that it can be up to three months before someone will receive benefits. This can encourage petty theft and recall measures being taken."

Whether the treatment of older prisoners complies with equality and human rights legislation

29. The prison regime is designed with the younger majority—and their preparation for education and employment on release—in mind. Outsourced education contracts have restricted the availability of programmes and courses for those who are not eligible for release until retirement age. Alternative meaningful and purposeful activity for this group is poor. Few resources are available to develop these services, with low-level activities such as games (carpet bowls and dominoes) being the norm.

30. Some prisons have written their own policy for older prisoners and some have established older prisoners' forums to encourage dialogue and open communication so issues can be raised, but this isn't consistent. Some induction procedures are robust whilst others would prove difficult for some older people. Not all areas of some prisons are accessible for people with disabilities which is case for concern. Not all prisons offer age-specific activities, though most have some type of gym provision designed for older prisoners. Not all prisons can offer offending behaviour programmes for people with mobility, sight or hearing issues. The rate of pay for prisoners of pensionable age who are not working varies significantly from prison to prison and is open to litigation.

31. We believe this leads to potential for litigation to be brought where the treatment of older prisoners does not comply with Equality and Human Rights legislation.

Whether a national strategy for the treatment of older prisoners should be established; and if so what it should contain

32. Davies, The reintegration of elderly prisoners, 2011: "there is an absence of a cohesive strategy in England and Wales to manage [older prisoners'] needs."

33. A national strategy should be established to ensure equality and fairness in the treatment of older prisoners and to make the most of resources available. The strategy should include:

- A requirement for all prisons to provide an older prisoners' forum, which link directly to the prison's equality management.
- A nationally consistent rate of retirement pay.

— Dedicated older prisoners' accommodation areas.

— Training for prison staff on issues affecting older prisoners (ageing, behaviour, health).

— Resettlement services for older prisoners incorporating assessment of health and social care needs.

— Defined "older prisoner" responsibilities within the Equality Officer role description.

— An information sharing protocol to be agreed between prisons and healthcare providers for all older prisoners.

— A monthly multi-disciplinary meeting in prisons to discuss older prisoners as a group and individual case plans where there is an increase in need.

— Improved links to be developed between prisons and local Social Services.

— Increased use of ROTL (Release on Temporary Licence) for eligible older offenders prior to release to help prepare for life outside prison.

— A commitment to review the management of end of life care and natural age-related deaths in custody.

APPENDIX 1

A LIST OF THE PRISONS WORKING WITH RECOOP

HMP Dartmoor
HMP Channings Wood
HMP Erlestoke
HMP Verne
HMP Leyhill
HMP Parc
HMP Usk
HMP Bullingdon
HMP Holloway
HMP Bure
HMP Sheppy Group
HMP Whitemoor
HMP Bullwood Hall
HMP Wayland
HMP Littlehey
HMP Leeds
HMP Buckley Hall
HMP Wymott
HMP Haverigg
HMP Low Newton
HMP Lowdhan Grange
HMP Featherstone
HMP Shrewsbury
HMP Drake Hall
HMP Whatton
HMP Stocken
HMP Oakwood
HMP Long Lartin
HMP Newhall
HMP Everthorpe
HMP Kennett
HMP Exeter
HMP Guy's Marsh
HMP Dorchester
HMP Shepton Mallet
HMP Swansea
HMP Kingston
HMP Isle of Wight
HMP Coldingley
HMP Eastwood Park
HMP Chelmsford
HMP Highpoint
HMP Bedford
HMP Blundestone
HMP Hollesley Bay
HMP Peterborough
HMP Manchester
HMP Askham Grange
HMP Liverpool
HMP Kirkham
HMP Holme House
HMP Garth
HMP Stafford
HMP Dovegate
HMP Leicester
HMP Gartree
HMP Stoke Heath
HMP Nottingham
HMP Kennett
HMP Norwich
HMP Risley

Written submission from the Association of Members of Independent Monitoring Boards

AMIMB SUBMISSION TO THE JUSTICE SELECT COMMITTEE'S INQUIRY INTO ELDERLY PRISONERS

WHO WE ARE: By law, every prison and immigration removal centre must have an Independent Monitoring Board (IMB). IMB members are volunteers from the local community, appointed by the Secretary of State and have a duty, established by acts of parliament, to: satisfy themselves as to the humane and just treatment of those held in custody and (in prisons) the range and adequacy of the programmes preparing them for release.

IMBs monitor to ensure that people in custody are treated fairly and humanely and that they are offered adequate preparation for return to society. They are the independent eyes and ears of the community and offer a totally unbiased view of what is really happening in our secure establishments.

AMIMB, the Association of Members of Independent Monitoring Boards is a membership organisation that was founded in 1980 to introduce consistent standards and reinforce the independent nature of the role of prison monitoring. Our members have unfettered access to their designated establishment and the right to talk to those in custody out of sight and hearing of staff.

This submission is a summary based upon 33 annual reports (all but two from 2011–12) of IMBs who have raised issues regarding elderly prisoners and does not necessarily represent the views of individual AMIMB members.

SUMMARY

— There is a very mixed picture of how elderly prisoners are treated across the prison estate, with inconsistencies in healthcare screenings, regime activities, how their physical needs are being met.

— Most prison buildings and sites are not suitable for an aging population; the cells in the Victorian jails are not wide enough for wheelchair access. Many adaptations are having to be made across the prison estate including stairlifts, grab rails, end of life cells.

— Growth in this group of prisoners is placing extra pressure on prison resources (people and budgets) when each prison is having to set its own local policy as part of conforming to the equality policy and "re-invent" the wheel each time.

— Social Services, NOMS (prisons and probation), Healthcare, Parole Board, Local Authorities need to work together to establish a national strategy for the management of older prisoners during imprisonment and on release so they may receive the most appropriate treatment delivered by appropriately trained staff.

1. *Buildings—fit for purpose?*

1.1 Concerns have been expressed about the unsuitable conditions to locate elderly prisoners, this relates to the buildings as well as cells.

> *"Like many prisons Frankland was designed for fit young men, making life difficult for the rising population of older prisoners. There are 132 prisoners who are over the age of 55 and this number will invariably continue to increase as sentences for those in a high security prison tend to be lengthy." IMB Frankland*
>
> *"As the prison population ages there is an increasing need for specialised units for older prisoners. This has been addressed in the case of male prisoners. Is there any hope of such placements for the elderly female prisoner?" IMB Holloway*
>
> *"Additionally, bunk beds are considered by the Board to be totally unsuitable for elderly, and often, infirm or weak prisoners and present a potentially serious health and safety issue. Some bunk beds have no access ladder. One prisoner stated that he accesses his top bunk 'by standing on a chair'; a poor state of affairs for very elderly prisoners." IMB Wymott*
>
> *"As highlighted in last two years reports the number of elderly and disabled offenders raise concerns that the in-cell and other facilities for such offenders continues to be inappropriate in many cases" IMB Bure*
>
> *"We welcome the increased attention being given at Coldingley to the needs of older prisoners, taking account of the fact that many prisoners have led a life which has caused them to age more quickly than the general population. Coldingley's industrial role is likely to limit its ability to accommodate many older prisoners, and 80% of its accommodation—in the four original wings—cannot readily be adapted to the needs of older prisoners." IMB Coldingley.*

1.2 Some prison governors have recognised the need of the aging population and have converted wings to address the need, but with budgetary constraints not all governors/directors are able to do anything about this. Spending money on conversions does not appear to be based upon any specific criteria like the number of prisoners over 60, average length of sentence or type of offence.

> *"L Wing, the elderly lifers unit, now appears to be housing more elderly prisoners from the local region, rather than nationally as before. It has the 'feel' of a rather sad old people's home with fewer visitors and little to do. The rather cheerless large sitting room with a games table and big TV is often nearly empty. E Wing is to be re-rolled as a quieter, 'mature unit' following the re-roll in March 2012, aiming to provide prisoners with a peaceful environment away from the hubbub of the other wings." IMB Norwich*
>
> *"Discussions about developing a dedicated Older Prisoners unit are ongoing and prisoner representatives express some frustration at what they perceive to be the slow pace of implementing this initiative." IMB Altcourse*
>
> *"The Board is very pleased to report the conversion of J Wing to use as the Older Prisoner and Social Care Wing unit. It is undoubtedly the case that this could serve as a model for other prisons. The dedication of Wing staff towards the success of this initiative is exemplary. Unfortunately, however, some cells still have no access to hot water. Although a pump has been installed, some cells need an individual pumping system." IMB Birmingham*

1.3 There is a recognition by IMB members of the pressure on resources especially when delivering adaptations to meet the needs of the aging population.

"We also acknowledge that the Governor and her team are doing all they can to mitigate the issues faced by the elderly and disabled where they can [purchasing aids to help those with mobility problems and opening flat access showers on each of the six wings]. However with the growing elderly population it is essential that better provision is made for these offenders." IMB Bure

"There are a limited number of cells adapted to meet specific needs and conversion of a standard cell is problematic. As a consequence wheelchair users are sometimes held on healthcare, taking up 'beds' for prisoners with more urgent healthcare needs. Wheelchair dependent prisoners therefore have difficulties in accessing a standard regime of activities, employment and association whilst on healthcare." IMB Altcourse

"Recognition of increased prisoner numbers over the age of 50 has been responded to by the prison where cost is not a major implication. However, investment in updating facilities is urgently required, The Board has requested the prison to consider various facilities for disabled prisoners over the last year. When marginal cost has been involved the Governor has responded positively to our request. The availability of wheelchairs has been noted. However, the more pressing needs require investment. The most urgent, outstanding needs are:

(i) An accessible shower for disabled prisoners on each wing (with seat and ramp).

(ii) Provision of at least one cell providing wheel chair access.

Due to the increasing number of older and disabled prisoners throughout the Establishment it is the view of the Board that more funding is required without delay. Respect and dignity are lacking when disabled prisoners are unable to shower and move in and out of cells in a wheelchair if required. Installation of more disability aids are urgently needed." IMB Channings Wood

"Showers on the wings are usually cleaned to an acceptable standard and there has been an improvement and increase in facilities for prisoners with disabilities. Most also have some privacy screening, with the notable exception of Down Tor which has no screening, grab rails or seats." IMB Dartmoor

"Only one cell in the main prison has an adequately wide door for wheelchair access. For these men access to daily showers was not a reality and getting to other areas of the prison such as the chapel, visits or workshops was difficult or limited. It was decided that these prisoners should be lodged in the prison's inpatient facility, or the drugs unit, while places were sought elsewhere. It was disappointing that accommodation for these wheelchair users was not sought at the earliest opportunity. It was a failure at Area level that no accommodation could be found for them at any other establishment." IMB Wandsworth

"Lifts and stair lifts are positioned in the prison so that there is access to all areas" IMB Swaleside

"The equality team is very aware of the increasing number of older residents and hence the probability of more residents with disabilities. It is noticeable when walking round the prison the additional facilities to cater for these people which includes, ramps for wheel chairs, grab rails in showers and toilets and the presence and usage of wheel chairs which at one time was a very rare sight." IMB New Hall

2. *Regimes for the Older Prisoner*

2.1 Whilst there is evidence of some excellent practice of activities for the retired and disabled prisoners in some establishments there is also some very sad evidence where this group of prisoners can be locked up in cell for 22 hours a day. Many of the activities are delivered through third party agencies and charities.

"The prison is beginning to recognise the needs of the older prisoners and to address the lack of activities specifically targeted at this group of prisoners. The older prisoners 'Out and About' group on the Reception site is well attended each Thursday afternoon, providing an opportunity for older prisoners throughout the Reception Site to meet together and participate in general activities. L wing continues to have limited activities, although Age Concern and members of the Official Prison Visitors (OPVs) visit the wing regularly." IMB Norwich

"The Diversity Centre The development and organisation of this centre with its own day accommodation offering occupation and activities for older prisoners continues to extend the opportunities on offer. It is also now open to prisoners under 50 who have physical, mental or psychological difficulties. Activities have expanded and there are now workshops:

— *Making wooden boxes which are sold for charity.*

— *Repairing old garden tools for inner city gardens and allotments.*

— *Mending and cleaning clothing for prisoners on release.*

Servicing wheel chairs for the Red Cross.

A garden has been created outside the Diversity Centre and grants obtained to provide low-impact exercise machines. A pilot pre-release course was run for those who have served many years in prison." IMB Dartmoor

IMB Forest Bank asked the Minister: "With the increase in numbers of prisoners aged 65 and over being given significant custodial sentences, what measures are being taken to find and fund purposeful activities for them as they are not required to work in the prison".

"Retired prisoners were offered a social room each day" IMB Stafford

"Older Persons—It is disappointing to note that the Fifty Plus 'Time Out' Community Centre, which the King's Fund initially pledged funding for in August 2009, still was not completed in this reporting year, although advances were made with completion due in 2012." IMB The Verne

"A new protocol has been put in place for those residents aged 60 or over who do not have to work, having reached 'retirement' age. This allows them, subject to risk assessment and IEP status (Incentive and Earnings Privileges) to be allowed out of their rooms on the wings during working hours." IMB New Hall

"The Prisoner Representatives hold an 'Over 50's Club' twice a week which has proved to be very successful and is well attended, if only for its recreational value." IMB North Sea Camp

"For those prisoners who do not go to work, either because they are medically unfit or because they are over the age of 65, far too much time is spent behind their doors, typically 22 hours per day." IMB Risley

2.2 The gym staff are praised for the activities on offer specifically to cater for the needs of the elderly and infirm and are in evidence in a large number of prisons.

2.3 The use of prisoner forums is in evidence at a large number of prisons, however in some instances there does not appear to be a distinction between the elderly and the disabled.

3. *Prison staff*

3.1 Disability Liaison Officer. The lead for older prisoners in the prison tends to be given to the Disability Liaison officer who combines the overseeing of the elderly with those with disabilities. However given the budgetary cuts there are many instances where this officer has been re-deployed.

"The DLO has a busy role in healthcare and unfortunately does not have sufficient time available to do justice to the needs of the disabled and older prisoners There have been some problems during the reporting year caused by cross-deployment of the Race Equality Officer and the Disabled and Older Prisoner Liaison Officer. Attendance at Forums and other meetings by Staff Diversity Officers has been poor." IMB Woodhill

"The Board was informed last year that priority would be given to providing more time to the DLO post which is 100% funded by Care UK. This has not happened and the Board repeats once again that the DLO role should be reviewed with the objective of providing sufficient time and support to carry out all duties effectively." IMB Frankland

"The Board is concerned regarding the provision of a part time disability officer who is frequently required to perform other duties during his shift. The Board considers that only a full-time officer or equivalent should be in place" IMB Wymott

3.2 Training. Many IMBs acknowledge the care and dedication of many prison staff, who are proactive in "caring" for the needs of the elderly, but it is also acknowledged that they have received no training to carry out these tasks.

"In the main prison officers are neither trained nor qualified to act as 'carers of the elderly'." IMB Bure

"Given the further reductions on budgets locally, will NOMS be introducing centrally driven initiatives to ensure appropriate input from social services and specialist training to staff who will be dealing with prisoners' needs ranging from Parkinsons Disease to dementia?" IMB Littlehey

4. *Healthcare*

The healthcare provision for the aging prison population is inconsistent with some fabulous examples of best practice. Healthcare provision for prisoners has to replicate the provision anyone would receive outside, the question has to be asked as to why healthcare has to pay for the prisoner escort to access specialist services, is this how the healthcare provider justifies the cost of some of the services put in place to meet the needs of the elderly in one establishment. For example the basic cost of putting in place an end of life provision is £100,000 not including staff training, drugs, nursing care etc. At Whatton the end of life suite was used 3 times last year for the last 36 hours of three prisoners lives.

Examples of good practice include:

"The Health Care Manager has been able to obtain £2,000 from the Kings Fund to re-furbish two side wards into one unit which will accommodate seriously sick patients who need extra care. Four Nurses have been trained in the area of nursing, which is in line with the Liverpool End of Life Pathway which is accepted as 'Best Practice'. This year, to date, three prisoners have died in custody from natural causes and there have been 36 bed watches totalling 305 days." IMB Forest Bank

"HMP Whatton has one of the highest rates of death by natural causes of any prison in England and Wales and the need to provide accommodation for terminally ill prisoners to die with dignity and in surroundings catering for their needs is crucial.

The role of specialist nurse for older prisoners (aged 55 and over) which began two years ago continues and is applauded by the board. Prisoners who would not make the effort to visit the Healthcare centre are seen approximately once a month by the specialist nurse who can assess their needs within their own environment. Any medical needs she finds can then be addressed. The nurse involved has told us that she feels that it is an important service to the older prisoner as their needs could be so easily overlooked in a busy and bustling high security environment. The scheme is very popular with older prisoners."

"Elderly prisoners are now given a certificate upon release detailing any medical condition and treatment given. This can then be handed to their General Practitioner (GP) so that he/she is fully aware of any health issues." IMB Manchester

"The range of clinics regularly provided: diabetes, acupuncture, smoking cessation, alcohol awareness, epilepsy, coronary heart disease, asthma, ENT (Ear, Nose and Throat) and GUM (Genitourinary Medicine)." IMB Northallerton

"A cell on I wing is being prepared for prisoners with dementia, HMP Stocken held four such prisoners. All new arrivals are offered cardiovascular risk assessment, and all older residents have now been processed. If a s' risk is assessed at 30% or more, the matter is pursued. Clinics specifically designed for older prisoners are now held at regular intervals." IMB Stocken

"Abdominal Aortic Screening for the over 65 has commenced." IMB Swaleside

"There are a number of regular clinics dealing with conditions such as diabetes and heart disease. The diabetes clinic has just completed 12 months and is reported to have made a 'huge difference'."

"There is a recently recruited Chronic Heart Care Nurse. This facility has been made available by the British Heart Care Foundation which is providing the funding for three years." IMB Wakefield

"Screening for cardio-vascular disease covers a broader age-range than in the community (30 to 74) because of lifestyle differences in the prison population. The Healthcare team have also now introduced wing-based group sessions aimed at supporting prisoners who want to make a lifestyle change."

"Screening for bowel cancer has also been introduced although that has proved more difficult to set up in a prison context because of the way in which standard NHS screening procedures are carried out. Healthcare staff are addressing the problem but the Board is concerned that the lack of privacy in double cells contributes to the difficulty in following standard procedures." IMB Wymott

5. *Other areas*

5.1 The role of social services is not clearly identified with very few IMB reports mentioning that there is any representation in the prison at all.

5.2 RECOOP and Age UK have been mentioned in providing some services but it appears to be locally negotiated.

5.3 Only one report mentions preparing prisoners for release and how to look after themselves in basic needs like cooking, washing. (IMB Littlehey)

5.4 Care plans are mentioned when talking about prisoners with disabilities (but not in all cases) and not for elderly prisoners.

5.5 It is evident that parole boards do not currently take into account age, mobility, disability when assessing risk. How often are compassionate and medical reasons taken into account for release? (For example prisoner X is an IPP prisoner over tariff who now has memory problems which make him unsuitable to complete his offending behaviour programme. The parole board will not release him until he has completed his programme.)

5.6 It is clear from the above that if older prisoners are continued to be located in the existing prisons a national strategy for the management of them is required which can identify the most appropriate locations, given the constraints of many prisons; deliver consistent standards across the prison estate; it will provide clear lines of accountability between healthcare , the prison, social services and other providers; it will deliver specific guidance on mobility aids; healthcare screenings; end of life requirements; staff training; care plans; regime activities and resettlement needs.

March 2013

Written submission from the Royal College of Psychiatrists

This submission is from the Forensic Faculty of the Royal College of Psychiatrists.

1. *Introduction*

1.1 The Royal College of Psychiatrists (RCPsych) is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

1.2 Forensic psychiatry is a specialty which helps mentally disordered people who are a risk to the public. It covers such areas as: the assessment and treatment of mentally disordered offenders; investigation of complex relationships between mental disorder and criminal behavior and working with criminal justice agencies to support patients and protection of the public. Forensic psychiatrists work side by side with others including the police, probation service, courts, Crown Prosecution Service and prisons.

2. *Are the responsibilities for the mental and physical health and social care of older prisoners clearly defined?*

2.1 The mental health of older prisoners is currently managed by a combination of primary care and mental health in-reach teams, who work across all ages in the prison estate. These are relatively under-resourced in absolute terms (approximately £20 million) and also in relative terms (as a proportion of the total health spend in prisons compared to the situation in the community). As there are rarely more than a few older prisoners in any particular prison and their mental health problems are mostly the same as younger prisoners (ie alcohol, depression and anxiety disorders), current in-reach teams should be able deal with such mental health problems if they are identified. Dementia remains rare in prisons, but in such cases, mental health teams should liaise with local old age psychiatry services for advice on management of cases.

2.2 The social care of older prisoners is problematic, however, as prison health staff will have very little knowledge or experience of liaising with community old age services. An older prisoner lead for each prison is one such solution to this, and many prisons have adopted this strategy. If a national strategy is adopted (see below), then delineating the possible roles of such a lead will be a dramatic improvement on the current ad hoc arrangements that exist in each prison.

3. *What environment and prison regime is most appropriate for older prisoners and what are the barriers to achieving this?*

3.1 It is currently uncertain if specialist units are the most appropriate ones for older prisoners. There are reasons that would suggest that they might be, including a more suitable physical environment (for example for those who lack full mobility), better specialisation, and the potential to offer age-appropriate activities, groups and other forms of rehabilitation.

3.2 However, some research suggests that some older prisoners do not want to be in wings for older people and would rather associate with younger prisoners, for whom they may act as a positive influence. Furthermore, family support may be more available, as sometimes specialist units are far away from the families of such prisoners, and such support is important for post-release health care. One possible solution that we recommend is that individually tailored care plans are agreed for each older prisoner to meet their particular combination of health, social, and family needs. An older prisoner lead could act on such a care plan, and arrange for transfer to a specialist older prison wing if deemed appropriate. However, more research needs to be conducted to investigate outcomes for older prisoners, and this needs to be done in the form of a randomised trial. Otherwise, the prisoners who choose specialist units will not be comparable to those who do not.

4. *The effectiveness with which the particular needs of older prisoners are met*

4.1 The evidence to date suggests that older prisoners' mental health needs are often not identified, and even when they are, treatment does not follow best practice. Part of this is a consequence of the prison environment, where prisoners who are disruptive and come to the attention of prison staff will receive most attention. There are potentially important training issues involved, as the presentation of depression and other mental health problems in older people is different to that in younger prisoners. The fact that these needs have been overlooked was highlighted in a 2004 report into older prisoners by Her Majesty's Inspectorate of Prisons: *"No problems—old and quiet": old prisoners in England and Wales* following extensive fieldwork around the country. Few prisons have regular input from a consultant old age psychiatrist or other members of an older adult multidisciplinary team, but this should considered for those prisons with higher numbers of older prisoners.

4.2 In the social care of older prisoners, there are wide variations in practice, with examples of good practice in the prisons included in the Isle of Wight Project. However, some prisons, particularly those with small numbers of older inmates, have little understanding of the issues involved in providing social care for social prisoners with the result that local ad hoc arrangements emerge that may be inadequate.

5. *The effectiveness of training given to prison staff*

5.1 We are not aware of any evidence that speaks to this, and research evaluating current training is necessary. The case for specialist training is strong as older prisoners present unique health needs that we know are not currently identified. To remain effective, training programmes and materials need to be regularly updated and refreshed and there needs to be a mechanism for this to be co-ordinated with input from professionals both from within the prison system and from those used to dealing with late-life issues in the community.

6. *The role of the voluntary and community sector and private sector in the provision of care for older people leaving prison*

6.1 Different models of provision of aftercare need to be examined, and information on successful pilots shared with the prison estate. However, we know that meeting the large burden of health problems in older prisoners means that close liaison with existing health services is necessary, and the voluntary and community sector cannot replace this. We are aware that a randomised trial is currently starting at the University of Manchester examining one model of aftercare, and the findings from this trial need to inform and be incorporated into any national strategy.

7. *The effectiveness of arrangements for resettlement of older prisoners*

7.1 There is robust international evidence that the older you are, the less likely you are to offend, particularly in sexual offenders, where international studies have pooled information to demonstrate this. The extent to which parole boards are aware of this, and the capacity of current instruments to assess dangerousness, is unclear. Nevertheless, it occasionally means, from our experience, that older men spend longer in prison that their risk of serious reoffending would suggest.

8. *Should a national strategy for the treatment of older prisoners should be established?*

8.1 There is an urgent and pressing need for a national strategy for the treatment of older prisoners; we note that researchers have been calling for this for many years. The Forensic Faculty of the Royal College of Psychiatrists would welcome a national strategy for older prisoners and would be willing to support and assist in the development of such a strategy, which would benefit from the participation of a wide range of stakeholders, including primary care, specialist old age medicine and psychiatric input, probation, and the third sector. It should include: identification of the training required for prison staff to better identify older prisoners' health needs; the development of minimum standards for improving the health outcomes of older prisoners; good practice guidelines, and thresholds for referral to specialist psychiatric and old age medicine for further assessment.

March 2013

Written submission from Restore Support Network

1.0 Introduction

1.1 Formerly known as Restore 50plus, Restore Support Network was established as an older prisoners users group in 1996 by Stuart Ware and six others serving custodial sentences in Bedford, Lincoln and The Mount prisons. The network has grown so rapidly that it became a Limited Company "not having a share capital" in 2011 and has just submitted an application to the Charity Commission for charity status.

1.2 After his release from prison in 1996, its Director (Stuart Ware) has continued to lead a volunteer team of reformed older offenders to offer peer support to network members. Stuart obtained his PhD at University of Sheffield (2007) that focused on the care and resettlement needs of older people in prison.

1.3 In 2001, it approached Age Concern South West regarding establishing a pilot for older prisoners in the region. Consequently Restore worked in partnership with ACOOP in delivering social care programmes in Dartmoor, Exeter, Channings Wood, Shepton Mallet and Leyhill prisons. It is now an established as charity and known as RECOOP.

1.4 Restore was a co-founder of Footprints in Dorset. Footprints has achieved the MBF Approved Provider Status. In 2010–12, RSN delivered the OPAC (Older Prisoners After Care) programme within Footprints (See attached Final Report on OPAC Pilot, as evidence of voluntary sector collaboration in the provision of care and resettlement).

1.5 As service users group representing the needs of older prisoners and older reformed offenders in the community, it has been a founder member of Age UK Older People in Prison Forum (See Age UK's submission to the Justice Select Committee). Restore also represented service user interests on the Dept of Health, Offender Health Unit's Older Prisoners Action Group (OPAG) to ensure the needs of older prisoners health and social care were met in the prison environment. As an example of good practice, this resulted in the publication of the Dept of Health "Pathways to care for older offenders: a toolkit for good practice" in 2007 (See page 29—Restore as good practice example).

1.6 The CAF Final Evaluation Report (See attached) identified hindrances to the delivery and implementation of CAF in HMP IOW, duplication of assessment tools (1.0), lack of understanding CAF (2.0) no integrated needs assessments prior to CAF (3.0), no previous social care assessment (4.0), lack of transfer of information between service providers, including transfer to other prisons or release (5.0), and restrictive IT practices in sharing of information (6.0). Feedback from Restore service user confirms these issue applied to many other prisons and were not peculiar to HMP IOW.

1.7 The CAF Evaluation report identified good practice influences by the CAF initiative and produced good practice examples. Of specific interest is the evidence produced of the cost effectiveness of CAF interventions, especially three examples where the quality of life and was maintained on release that had a knock-on effect of reducing recall (See 5.2 and 4.7/8).

2.0 The CAF IOW Health and Social Care Project (2010–2013)

2.1 In order to capture the service users perspective, Dr Ware was commissioned by the Dept of Health CAF Unit to evaluate the only Common Assessment Framework pilot in the prison estate in HMP IOW. He has already submitted the IOW Council submission to the Select Committee, together with its report—which used information provided by the evaluator in his final report.

2.2 As an example of partnership initiatives, the IOW CAF developed an integrated common assessment service within HMP IOW that ensured prisoners would have access to a range of adult social care facilities. This included the carrying out of care assessments, referrals to other agencies, provision of social care equipment (ie disability aids in cells and showers, personal alarms etc) and the running of social care "surgeries". In the words of the latest Chief Inspector of Prisons Report on HMP IOW it was noted that "The common assessment framework project was a good example of inter-agency working to meet prisoners' care needs". CAF is now scheduled to close on 31st March 2013 leaving a legacy of social care improvements throughout the prison estate.

3.0 Responses to Questions Raised by Justice Select Committee

3.1 RSN would suggest that the Committee follows research evidence that the older prisoner population ages 10 years biologically in comparison with the same age group in the community (Wahadin, A., "Reconfiguring Older Bodies in the Prison Time Machine", Journal of Aging and Identity, 7/3: 117–93, 2002) and Aday, R., Aging Prisoners: Crisis in American Corrections. Westport, CT: Praeger Publishers, 2003). Hence evidence provided by Restore commences with age 50.

3.2 We confirm the findings from HM Chief Inspector of Prisons in its Thematic Review of older prisoners (2008) that there should be a national strategy for the treatment of older prisoners. It is our view that there is a greater need for such a strategy now than ever before, due to radical overhaul of the NHS, prison and probation services that include the opening up of these services to private and voluntary involvement. Commissioning of these services should take into account a national strategy for care and resettlement of older prisoners.

3.3 The Law Commission and subsequent Health and Social Care White Paper acknowledges the need for the Government to decide whether or not social care should the responsibility of local authorities or prisons and that this may require further legislation. This is a grey area and Restore has identified case stories where older prisoners have been let down by local authorities and the releasing prison.

Example:
72 year-old "Harry" with multiple disabilities released from prison with no papers. It was known before his release that he had no accommodation on the day of his release when he returned to his home area. The prison resettlement officer contacted Restore Director, who in turn got in touch with Restores' voluntary area co-ordinator for Devon and Cornwall (Steve Trelease). Steve contacted the local Salvation Army hostel and arranged emergency accommodation and set up appointment with local housing. Housing accepted "Harry" was its responsibility and agreed to provide supported housing. This should have been arranged prior to release as part of a "through the gate" programme.

3.4 While most older prisoners would prefer to remain part of the prison population and can have a stabilising effect on younger inmates, feedback from Restore members confirms a growing concern for separate wings/ units where those with care and disability needs can have their needs met.

3.5 The Justice Select Committee should find further examples of good practice and background information in the CAF Final Evaluation Report (attached).

4.0 Restore Filling a Much Needed Gap During a Period of Rapid Changes

4.1 Based upon evidence provided with this submission, Restore has agreed, subject to funding, to work collaboratively with other agencies to provide a "through the gate" care and resettlement service for older prisoners. This will be a follow-up to the Footprints/Restore OPAC (2008–10) pilot and the CAF IOW (2010–13) initiative. This will be in the South and South West regions but with the intention of rolling it out nationally. It will be called Opening Doors: through the gate mentoring and is aimed to start September 2013.

Subject to approval by respective bodies, it will involve the following collaborations with Restore in Devon, Dorset, Hants and IOW Prisons and Probation Area Trusts:

- Pre-release care and resettlement assessment.
- Personalised pre-released care and resettlement through the gate "passport".
- CRB vetted mentor from pilot areas to deliver pre-release programme and meet older person at prison gate and commence resettlement mentoring.
- Footprints to train and accredit mentors.
- Prison Education to run peer mentoring accredited courses that link with community peer mentoring courses (accredited NVQ etc).

4.2 In delivering the above proposed Opening Doors initiative, in co-operation with other agencies, such as Age UK and Footprints, Restore believes much of the previous achievements and lessons learned will not be lost. The evidence already produced for the Justice Select Committee can be built upon and that further good practice will continue to inform the committee.

March 2013

Written submission from Leigh Day

Introduction

Leigh Day has a dedicated Prison Law Team, which forms part of the Human Rights Department of the firm. The team, headed by Sean Humber, are recognised as leading experts in prison law in all of the legal directories.

The team's areas of specific expertise relates to healthcare, discrimination and human rights within a prison context. Over the last decade, the team has successfully acted for prisoners in a wide range of cases, including: personal injury and clinical negligence claims, unlawful discrimination claims, breach of human rights claims, judicial reviews, European Court of Human Rights claims and Inquests. Many of these cases have been on behalf of older prisoners.

In recent years, the team are being approached by an increasing number of older prisoners with concerns over their treatment and care in prison. The common issues running through those concerns are:

- A failure to allow them to fully and fairly participate in the prison regime;
- A failure to provide adequate health and social care; and
- A failure to adequately assess and address their disability needs.

The aim of these submissions is to explore these issues further, and draw upon our experiences, and those of our clients, to assist the Inquiry in identifying some of the more common problems faced by older prisoners.

Summary

- Prisons and prison regimes are not designed for, and do not adequately cater for, the needs of older prisoners.
- The provision of health care to older prisoners is variable and the provision of social care for older prisoners is virtually non-existent.
- The disability needs of older prisoners are routinely not being adequately assessed and addressed.
- The various responsible bodies within prisons are failing to comply with their obligations under the Equality Act 2010 ("EQA") and the Human Rights Act 1998 ("HRA"). Both of these Acts offer older prisoners legal redress. The age discrimination provisions of EQA 2010, which only came into force in October 2012, may offer a particular avenue of legal redress for older prisoners.
- However, given the fundamental nature and extent of these failings, older prisoners should be given a greater opportunity for early release either on compassionate grounds or on home detention curfew.

Submissions

1. Regrettably, the starting point of our submissions is that older prisoners have a worse experience in prison in almost all aspects of prison life than younger prisoners.

2. Prisoners aged 60 or over are the fastest growing age group in prison.[19] Nonetheless, prisons and prison regimes are not designed for, and do not adequately cater for, the needs of older prisoners.

3. Therefore, older prisoners are already in a vulnerable position. However, they are also more likely to have chronic health problems and disabilities than younger prisoners and people in the same age group outside of prison.[20]

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[19] Prison Reform Trust, *Doing Time: The Experiences and Needs of Older People in Prison* (issued March 2008). The population of male prisoners over 60 in 2008 was more than three times the number it was in 1996 (ie 2,242 to 699, respectively).

[20] Prison Reform Trust, *Doing Time: The Experiences and Needs of Older People in Prison* (issued March 2008). More than 80% of male prisoners over 60 suffer from a chronic health problems or disabilities.

4. All prisoners face problems in accessing adequate health and social care, and in having their disability needs adequately assessed and addressed. However, the problems faced by older prisoners and the impact upon them are more acute.

5. Therefore, greater provision should be given for older prisoners. However, if such provision cannot be given, there should be greater opportunity for early release for older prisoners either on compassionate grounds or on home detention curfew.

6. These submissions are divided into five sections: First, the prison regime. Second, health care. Third, social care. Fourth, disability needs. Fifth, early release.

1. *Prison Regime*

7. Older prisoners should have the same access to prison facilities and activities as younger prisoners. Although they are not specifically excluded from any prison facilities or activities, in practice, older prisoners are more likely to be excluded.

8. The common problems faced by our older prisoner clients include:

— The inability to get to and from activities;

— The inability to participate fully in activities; or

— Intimidation or bullying whilst participating in activities.[21]

9. This means that younger prisoners are allowed to dominate the prison regime whilst older prisoners can often become isolated, spending the majority of their time in their prison cells. This situation appears to be tacitly accepted by prison staff who, all too often, turn a blind eye to it preferring a "quiet life".

10. However, in many cases, the situation could be simply remedied. Assistance to older prisoners or adjustments to activities could mean that older prisoners do not have to be excluded. For example, assisting an older prisoner to exercise, allowing an older prisoner to sit down during employment, or allowing an older prisoner to take regular toilet breaks during education.

11. Structures should be put into place to coordinate this assistance and these adjustments. For example, good practice could include an older prisoner lead amongst prison staff, and an older prisoner committee with older prisoner representatives.[22]

12. Furthermore, if this assistance or these adjustments cannot be made, alternatives should be considered, such as an older prisoner day room where older prisoners could spend time during the day whilst others are participating in activities, rather than spending it in their prison cells.

2. *Health Care*

13. Prisoners are entitled to the same standard of health care as those in the wider community.[23] However, all too often, this standard is not met.

14. Despite the responsibility for the commissioning of healthcare passing from the HM Prison Service to local Primary Care Trusts in a rolling programme from 2003 to 2006, the provision of health care across the prison estate remains variable.

15. The common problems faced by our older prisoner clients include:

— The failure to adequately assess their health problems upon their arrival at prison;

— The failure to contact their community GP and to obtain copies of their medical records to confirm their health problems and medications;

— Significant delays and practical difficulties in them seeing a nurse or a GP;

— A reluctance to prescribe them certain pain relief medications even if they were prescribed them before imprisonment, and a reluctance to prescribe them certain pain relief medications in possession or to dispense at certain times (which means that the medications are not taken at the correct times);

— A reluctance to refer them to hospital for investigation or treatment even if they were under the care of a consultant before imprisonment;

— Delays in attending the hospital appointment either because it has been cancelled or missed (which means that average waiting times are much longer than those in the community);

— Handcuffing during consultations or tests and examinations despite suffering chronic health problems or disabilities (which means they are denied dignity and privacy during treatment); and

[21] Prison Reform Trust, *Doing Time: The Experiences and Needs of Older People in Prison* (March 2008). Almost half (ie 48%) of the male prisoners over 60 interviewed stated they had experienced bullying or intimation either by prison staff or prisoners. Over 60% of those interviewed stated that they felt unsafe in prison.

[22] It should be noted that Prison Service Order 2855, *Prisoners with Disabilities* (April 2008), which was replaced by Prison Service Instruction 32/2011, *Ensuring Equality* (April 2011), had a section for older prisoners (ie Chapter 7), which made recommendations such as older prisoner leads and older prisoner committees. However, PSI 32/2011 has no such section and makes no such recommendations.

[23] Prison Standard 22, *Health Services for Prisoners* (May 2004)

— Transfers to other prison whilst waiting to be seen by or under the care of a consultant (which means they are often put back to the bottom of the waiting list or their treatment is disrupted).

16. It seems to us that there are three possible reasons for these problems.

17. First, with regard to older prisoners in particular, not all Healthcare Departments have specialist healthcare services for older prisoners. Older prisoners have very different health care needs in their nature and extent from younger prisoners. Therefore, those needs will often need to be assessed and managed differently (eg more time needs to be spent contacting their community GP and obtaining their medical records to confirm their health problems and medications, they need more regular appointments with nurse or GP or they need more regular hospital appointments).

18. Second, the fragmentation of health care services in prisons. The local Primary Care Trusts commission others to provide health care services in prisons. Those contracted to provide the healthcare services then often subcontract the different services (ie nursing, GP, substance misuses, mental health etc) to different providers. This fragmentation, leads to more gaps in the health care services, and makes it more complicated for prisoners to find out who is responsible for providing what service.

19. Third, the lack of cooperation between Healthcare Departments and Prisons. The effective delivery of healthcare services cannot happen without Healthcare Departments and Prisons cooperating effectively with each other[24], but there are often tensions in delivering these services.

20. Hospital appointments are good example of these tensions. The Healthcare Department is responsible for arranging a hospital appointment, and the Prison is responsible for escorting a prisoner to a hospital appointment. However, many hospital appointments are cancelled or missed because of lack a lack of cooperation between the two (eg the scheduling of hospital appointments during lunch time hours when there are not sufficient prison staff to provide an escort).

21. Older prisoners are in a particularly vulnerable position due to this lack of cooperation as they generally have more chronic health problems, such as diabetes, cardiovascular diseases and cancers, and, therefore, require more hospital appointments for monitoring and treatment.

3. *Social Care*

22. The provision of social care across the prison estate is virtually non-existent.

23. It is the experience of our older prisoner clients that:

— Local Authorities do not have any involvement with older prisoners.[25] Prior to their imprisonment, our clients are often assessed for and provided with social care in their homes by Local Authorities. However, upon their imprisonment, our clients have had little or no contact with Local Authorities;

— Prisons do not have the expertise, or effective systems, in place to provide social care to older prisoners; and

— Healthcare Departments are reluctant to refer for assessments and to provide social care to older prisoners because they do not consider that it is their legal responsibility to do so and, consequently, because they do not have funding to do so.

24. It seems to us that the main reason for this social care void within prisons is a confusion as to who is responsible for its provision (ie Local Authorities, HM Prison Service and/or local Primary Care Trusts).

25. Under the National Health Service and Community Care Act 1990, a Local Authority has a statutory responsibility for social care services to persons who are "ordinarily resident" in their local area. As such, a Local Authority are required to assess a person's need for social care services and this assessment then determines whether or not any services should be provided. However, it is not at all clear if a Local Authority's statutory responsibility includes prisons.

26. A report by the University of Birmingham into adult social care in prisons found that prisoners with social care needs were not receiving the same level of assessment and provision of social care services in prison that they would receive in the wider community.[26] The report found that this was because of a confusion as to who was responsible for social care services in prisons, caused mainly by a lack of clarity in the law.

27. The Law Commission's consultation and report into adult social care found, whilst the legal framework for social care does not exclude prisons, this was by oversight, rather than by design.[27] However,

[24] Department of Health and Home Office, *National Partnership Agreement between the Department of Health and the Home Office for the Accountability and Commissioning of Healthcare Services for Prisoners in Public Sector Prisons* (January 2007). Chapter 2 states that the partnership is underpinned by a shared responsibility between the NHS and HM Prison Service for the development of health services for prisoners on the basis of assessed need.

[25] HM Chief Inspector of Prisons, *"No Problems: Old and Quiet": Older Prisoners in England and Wales* (September 2004). The HM Chief Inspector of Prisons also found that, of those older prisoners interviewed, none had had any involvement with a Local Authority.

[26] University of Birmingham, *Adult Social Care in Prisons* (published June 2007)

[27] Law Commission, *Adult Social Care Review* (published February 2010) and *Adult Social Care Report* (published May 2011)

notwithstanding this, the consultation and report found that, in practice, the legal framework does provides "barriers" to the provision of social care services by Local Authorities to prisoners. These barriers include:

— The assumption that the Prison and the Healthcare Department are already providing social care services to prisoners;

— A lack of clarity as to which Local Authority would be responsible for the assessment and provision of social care under the "ordinary residence" criteria (ie would it be the Local Authority where the prisoner lived before they were imprisoned or the Local Authority where the prisoner was now imprisoned); and

— A lack of clarity as to whether or not the eligibility criteria can be applied to a prison context, and, if so, whether or not it would unfairly discriminate against prisoners (ie would a prisoner be eligible for social care before imprisonment but not during imprisonment).

28. Therefore, the consultation and report found that any reform of adult social care must expressly state whether or not prisoners should be excluded.

CASE STUDY

29. These barriers to social care have been borne out in a recent case that we have conducted on behalf of a female older prisoner client.

30. Since her imprisonment, she has been assessed by an Occupational Therapist as requiring assistance with her showering. This assistance was subsequently provided by Healthcare. However, she was only being provided with this assistance by Healthcare twice a week, and wished for assistance at least three times a week.

31. When we raised these concerns on her behalf, Healthcare's eventual position was that, whilst they were providing assistance, it was not their legal responsibility to do so as showering assistance was a social care rather than a health care need (although they did not state whose legal responsibility it was to meet he social care needs).

32. We subsequently wrote to the Prison, her "old" Local Authority (ie the Local Authority where she lived prior being imprisoned) and her "new" Local Authority (ie the Local Authority where she was imprisoned), asking them whose legally responsibility it was to provide her with showering assistance. In reply, they all denied legal responsibility.

33. However, whilst at the same time as denying that it was their legal responsibility to do so, her new Local Authority agreed to exercise their power, as distinct from their duty, to carry-out a social care assessment. Her new Local Authority also denied that, should the assessment find that she did have social care needs, it was their legal responsibility to address those needs.

34. Her new Local Authority subsequently sent a social worker to assess her on two occasions in December 2012. These assessments took place in the visits hall of the prison.

35. Her new Local Authority have subsequently been in correspondence with the Prison requesting that they also be able to assess her in her prison cell and wing (not least so they could see the showering facilities). However, in their most recent correspondence the Prison have refused her new Local Authority permission to assess her in her prison cell or her wing.

36. This recent case emphasises the confusion over who is responsible for social care provision in prisons. Furthermore, if the Local Authority (either old or new) does retain a legal responsibility when a person goes into prison, there is a lack of clarity as to the exact nature and extent of their powers (ie can the Local Authority make the Prison allow them access to her prison cell and her wing for the assessment).

4. *Disability Needs*

37. Disabled prisoners should be able to participate as fully and fairly in prison life as non-disabled prisoners.[28]

38. The HM Inspectorate of Prisons published a thematic report on disabled prisoners in March 2009.[29] The report found that:

— The needs of many disabled prisoners remain unmet;

— Disabled prisoners still consider that they have a worse prison experience across all areas of prison life than non-disabled prisoners; and

— HM Prison Service still have a considerable amount of work to do to ensure they fulfil their legal duties to disabled prisoners.

39. Regrettably, these findings very much echo the experiences of our older prisoner clients, whose own experiences are that:

[28] Prison Standard 8, Prisoners with Disabilities (issued April 2008), states "the Prison Service ensures that all prisoners are able, with reasonable adjustment, to participate equally and without discrimination in all aspects of prison life".

[29] HM Inspectorate of Prisons, *Thematic Report, Disabled Prisoners* (March 2009)

- There is a failure to adequately assess their disability needs, commonly the reasons for this are:
  - Local disability policies are either not in place or, if they are in place, do not sufficiently identify who is responsible for assessing their disability needs;
  - Disability questionnaires are not completed and, if they are completed, are not adequately completed;
  - Disability Liaison Officers do not have adequate training or time to complete an adequate assessment of their disability needs.
- There is a failure to adequately address their disability needs, commonly the reasons for this are:
  - There is a dispute as to the nature and extent of their disability needs (usually, caused by the failure to adequately assess and address them);
  - There are no disabled prison cells or, if there are disabled prison cells, they are already occupied by another disabled prisoner with greater disability needs or by two non-disabled prisoners who are sharing; and
  - The necessary aids and services are not provided because it is not clear who is responsible for providing them, there are no funds to provide them or they are considered a security risk.

40. It seems to us that there are three possible reasons for these problems.

41. First, the introduction of PSI 32/2011. As stated above, in April 2011, PSI 32/2011, *Ensuring Equality*, replaced PSO 2855, *Prisoners with Disabilities*. Along with removing the section on older prisoners specifically, PSI 32/2011 also removed the mandatory requirements for local disability policies, disability assessments and Disability Liaison Officers, which were previously required by PSO 2855. This was very much a backward step. Systems for assessing and addressing a disabled prisoners needs now vary from prison to prison, with some prisons not having any systems at all.

42. Second, disability needs are wrongly conflated with health problems. Although many disabled prisoners also have health problems, their health problems do not require their admission to the Healthcare Department. Nonetheless, many disabled prisoners are still admitted and over half of disabled prison cells are located in the Healthcare Department.[30] In the event that Healthcare are not willing and/or able to assist, then a disabled prisoners needs often remain unmet as the Prison do not have the expertise or efficient systems in place to meet them.

43. Third, there is no strategic approach to meeting the needs of disabled prisoners. There is no overarching system, which is managed at a national level by the HM Prison Service and which is able to match the needs of a disabled prisoner with the facilities of a prison which is able to adequately cater for those needs.

44. The reason for this is twofold. First, due to the lack of identification and reporting of disabilities, the numbers of disabled prisoners and the type of disabilities they have is unknown.[31] Second, the number and type of disabled facilities within the prison estate (and whether or not these facilities are in use) is also unknown. Therefore, HM Prison Service neither know the nature and extent of the disabled prisoner population nor whether or not they have the facilities to cater for it.

45. Typically, transfer decisions are made at a local level between governors, not knowing if a prisoner is disabled and, if so, whether or not the receiving prison has the facilities to cater for their needs.

5. *Early Release*

46. Given the fundamental nature and extent of the above failings, the question must be asked whether or not those older prisoners with chronic health problems and disabilities which are currently not being catered for in prison, should be in prison at all.

47. The Secretary of State for Justice and the Governors of prisons both have powers to direct the early release of prisoners, either on compassionate grounds or on home detention curfew. However, at present, the criteria for both of these powers do not sufficiently take into account the needs of older prisoners.

48. First, the criteria for early release on compassionate grounds includes a provision for those prisoners who are incapacitated or bedridden.[32] However, we are not aware of any older prisoner released on such grounds.

49. Second, the criteria for early release on Home Detention Curfew in exceptional circumstances includes a provision for prisoners who are infirm either by age or disability.[33] Again, we are not aware of any prisoner being released on such grounds.

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[30] Prison Reform Trust, *Doing Time: The Experiences and Needs of Older People in Prison* (March 2008)

[31] HM Inspectorate of Prisons, *Thematic Report, Disabled Prisoners* (March 2009). The HM Chief Inspector of Prison found that the Prisons LIDS system only recorded 5% of prisoners as disabled, but that, from her own review, 15% of prisoners surveyed identified themselves as suffering from some form of disability.

[32] Chapter 12 of Prison Service Order 6000, *Parole, Release and Recall* (March 2005)

[33] Prison Service Instruction 31/2006, *Impact of the CJA 2003 on HDC* (July 2003)

50. It would seem to us that, if the various responsible bodies within prisons are not able to adequately cater for the needs of older prisoners, and are failing to comply with their obligations under the EQA and the HRA, older prisoners should be given a greater opportunity for early release.

March 2013

Written submission from the Ministry of Justice

EXECUTIVE SUMMARY

1. On 30 June 2012 the prison population included 3,267 prisoners aged 60 or over, including 818 aged 70 or over. It is frequently argued that, because of the earlier onset of a range of health problems amongst the offender population, the term older prisoners should be used to refer to those aged 50 and over. If that definition is applied, there were 9,727 prisoners (over 11% of the total population) in the category. Each of these figures has increased considerably in recent years: since June 2003 the numbers aged 50 and over, and 60 and over have roughly doubled, and the rate of increase for those aged 70 has been even steeper.

2. The Ministry of Justice is committed to meeting the needs of the growing older prisoner population. The National Offender Management Service equality policy statement sets out a commitment to fairness for all, and this is supported by Prison Service Instruction 32/2011 Ensuring Equality that sets out the framework for the management of equalities issues in prison establishments. Prison Service Instruction 75/2011 Residential Services describes a commitment to ensuring that prisoners are supported and that their daily needs are met, and explains that this will be delivered by residential staff, who, through their engagement with individual prisoners, are expected to identify prisoners with any particular needs (including age-related issues) and make reasonable adjustments to their daily routine.

3. NOMS is committed to working with partners to address the issues presented by the older prisoner population. Most notably we are working with colleagues from Department of Health on health and social care issues. We also support the Older People in Prisons Forum that is co-ordinated by Age UK, which provides an excellent opportunity for us to engage with key stakeholders in this area, and grant fund RECOOP to build capacity for joint working across the voluntary sector.

Whether responsibilities for the mental and physical health and social care of older prisoners are clearly defined

4. The responsibilities for the mental and physical health care for all prisoners, including older prisoners, are clearly defined.

5. In England, until 31 March 2013 Primary Care Trusts have responsibility for primary healthcare, mental health and substance misuse services in public sector prisons and in four contracted prisons. The Ministry of Justice directly commissions primary healthcare in nine contracted prisons, with clinical oversight from PCTs, and these services are supplemented by PCT commissioned services.

6. From 1 April 2013 as PCTs are abolished the NHS Commissioning Board assumes responsibility for all health services, including substance misuse services, but excluding emergency and 111 services, for people in prison in England. Emergency and 111 services will become the responsibility of the Clinical Commissioning Group local to the prison.

7. For prisoners in Wales, Local Health Boards have continuing responsibility for health services in three prisons while the Ministry of Justice directly commissions primary healthcare at a single contracted prison.

8. Statutory responsibilities for social care of older prisoners are less well defined.

9. In May 2011 the Law Commission report on Adult Social Care found that although people in prison in England and Wales are not excluded from the provision of social care services, in practice a number of barriers exist to the provision of local authority funded social care services in prison. As a consequence there is a need to clarify eligibility—the Law Commission recommended:

> "*Recommendation 69*: If the policy decision is that prisoners should not be excluded from adult social care, then the legal framework must facilitate this policy, for example through the ordinary residence rules and eligibility framework. If the policy decision is that prisoners should be excluded, then the statute must make this position clear."

In July 2012 the Government White Paper "Caring for our future: reforming care and support" made a commitment to resolve this issue positively in England, and the Department of Health will shortly bring forward for parliamentary scrutiny proposals to clarify the framework for social care services for prisoners. The proposed approach is that in general people in prison should have their care and support needs assessed and, if required, services provided, by local authorities. This would provide consistency of approach and ensure prisoners are treated in an equivalent way to people in the community, in line with the approach to the provision of health services.

10. In the interim, while statutory responsibility is being clarified, prison governors and directors have a clear duty of care to prisoners and make local arrangements to meet the needs of older prisoners. Where prisons have successfully engaged Local Authorities for assistance with social care issues, the support provided is usually limited to the professional assessment of individuals' social care need and advice to the prison on meeting needs. Not all prisons have such a relationship with their Local Authority. Currently if social care needs are identified by the prison, such care is unlikely to be funded by a local authority. Some prisoners who receive a package of social care in the community have found this care is discontinued or difficult to access in custody. There are some examples of good practice including the Isle of Wight, Exeter and Manchester.

The effectiveness with which the particular needs of older prisoners including health and social care, are met; and examples of good practice

11. As explained above, the majority of prisoners are NHS patients, and from 1 April 2013 there will be NHS oversight of all health services delivered to prisoners. Health services are commissioned for prisoners to the same standard and effectiveness as those available to older people in the community.

12. Prison Health Performance and Quality Indicators enable assessment of how well the needs of prisoners are met, and include a specific measure of services for people with physical disabilities and older adults. This indicator covers assessment, joint working between the healthcare provider and the prison, health promotion, aids and adjustments and physical disability.

13. Amongst a range of examples of good practice is HMP Wakefield, where a Registered General Nurse has specific responsibility for the provision of care to the older population. All older prisoners, receive an annual assessment, and are referred as necessary to services such as podiatry, physiotherapy, optical and dental care (including a specialist provider for dentures) and the Mental Heath Inreach Team. This service is in addition to the primary care medical services that are available to the general population.

14. In the absence of clarity about statutory responsibility for social care provision, there is less assurance that the particular needs of older prisoners are consistently met.

15. Prisons have developed a range of responses to coping with prisoners with higher levels of care and support needs, including:

- support from healthcare services;
- support from voluntary sector agencies;
- provision of social care by prison officers;
- directly funding agency-provided social care;
- providing various forms of mobility assistance including wheelchairs; and
- facilitating care and support provision by other prisoners.

16. Whilst governors and directors work hard to ensure that they discharge their duty of care, there are cases in which prisons have found it very difficult to cope with the needs of individuals. The work described above to clarify responsibility and put in place a new framework for provision is designed to address this.

17. Amongst a number of good practice examples is HMP Hull, where Age UK Hull has supported a "buddy" scheme for older prisoners for several years. This has involved the recruitment and selection of peer helpers who provide basic care such as collecting meals, cleaning cells, assisting with bedding changes etc, whilst working also to empower and encourage those receiving the service to help themselves. Representatives of older prisoners and their buddies attend monthly prisoner forums where they can raise issues which impact on their quality of life in custody.

What environment and prison regime is most appropriate for older prisoners and what barriers there are to achieving this

18. We are committed to providing a safe and decent environment for older prisoners. Many of our older buildings provide barriers to achieving this, and we are working to adapt them to meet the needs of the growing older prisoner population. These include a range of adaptations to cells, showers and other facilities for people with mobility difficulties, as well as devising personal evacuation plans to ensure their safety. Peer support schemes of the kind described above can also assist in mitigating the impact of environments that were not designed with older prisoners' needs in mind.

19. In general, newer prison buildings offer better facilities than older parts of the estate for prisoners with mobility or disability needs, and we are committed to ensuring that any further new build units and prisons are more flexibly designed to provide appropriate environments, for example by providing cells that can be adapted for use by older and/or disabled prisoners. Work is at an early stage to consider how a strategic approach to the use of the prison estate can best ensure that older offenders are accommodated where their needs can best be met, and the where the built environment can facilitate this.

20. Ensuring that older prisoners feel safe has caused some prisons to develop accommodation areas specifically for them, and whilst this works in some places, it is not always the right solution. For instance Swaleside prison recently surveyed all prisoners over 55 about their preferences and the overwhelming view

was that they preferred integration, rather than a special older prisoners' wing. This is a good example of the importance of consulting prisoners, rather than making assumptions about their needs and preferences.

21. We are committed to providing a varied regime which includes age appropriate activities. Older prisoners are subject to the same offender management arrangements, and required to engage with activities to address their offending behaviour and resettlement needs. The main difference is for prisoners who have passed the state pension age, who are no longer required to work. Many of these prisoners choose to continue to work, but some will either be unable to or choose to "retire", and we are committed to ensuring that we provide suitable activity for them. For example, at Wakefield, where there are large numbers of such prisoners, the regime has been adapted to offer "core day unlock" to older prisoners who do not wish to attend off wing activities or paid work. This facility enables prisoners to remain active and to interact with their peer group.

22. More specific regime provision for older prisoners has been developed in conjunction with RECOOP, a charity based in the South West of England. For example, working in partnership with the Red Cross in Dartmoor prison, they support a wheelchair repair workshop and day centre for older prisoners. This improves the health and wellbeing of the prisoners, while teaching them new skills, including first aid, getting them involved in purposeful activity and making reparation to the community.

23. There is evidence that the level of compliance with the prison regime amongst older prisoners is better than that of their younger counterparts. In March 2012, 43.8% of all prisoners were on the enhanced level of the incentives and earned privilege scheme, compared to 58.6% of those aged 50–59 and 54.3% of those aged 60 and over.

The effectiveness of training given to prison staff to deal with the particular needs of older prisoners, including mental illness and palliative care

24. Mental health awareness training and diversity and equality training are included in the initial training of prison officers, and the needs of older prisoners are discussed in these contexts. In addition to this, a range of training and awareness interventions specifically about older prisoners are provided for use in prisons. For example, Nacro and DH have produced guidance and materials for an awareness session that has been delivered in a number of prisons, and RECOOP are delivering awareness sessions for staff as part of the capacity-building work described below.

25. We think that the availability of guidance and information for staff is more important than the delivery of awareness training. The NACRO and DH materials described above include a "Resource Pack for Working with Older Prisoners" that can be used by staff and prisoner peer supporters, providing a useful reference guide to the various statutory and voluntary and community sector organisations available to provide information, advice and guidance services for older prisoners. Age UK has produced "Supporting Older People in Prison: ideas for practice" which presents evidence, lessons from experience and practical solutions. These and other materials are now available via the RECOOP website, developed as part of the capacity-building project described below.

26. Prison discipline and healthcare staff work jointly and co-operate to support positive mental health outcomes for prisoners. For example both prison instructions and the prison health performance arrangements support collaborative working and information sharing to support suicide prevention, and partnership working is encouraged for people with learning disabilities.

27. "The route to success in end of life care—achieving quality in prisons and for prisoners" was published by DH in 2011 and aims to provide a practical guide to support both prison and health and social care professionals in delivering high quality end of life care to prisoners. The guide showcases good practice examples from across the health and prison communities in supporting prisoners at their end of life. Macmillan Cancer Support has also worked with prisons to develop a series of prison standards and associated tools so that more people can die in prison, where this is their choice, and fewer will be admitted to hospital unnecessarily. It is also hoped to reduce hospital and hospice lengths of stay, to increase the number of key staff with accredited end of life care and to raise the profile of palliative and end of life care within the prison community.

The role of the voluntary and community sector and private sector in the provision of care for older people in leaving prison

28. The recently published consultation document "Transforming Rehabilitation" sets out the Government's proposals for reforming the delivery of offender services in the community. One of the core features of these plans is integration with local partnerships: we are committed to designing a system to make use of local expertise and to integrate into existing local structures. We will align rehabilitative services with the role played by Police and Crime Commissioners so that our new market model will facilitate co-commissioning with them and other commissioners of public services, including health and social care commissioners. Potential providers will have to evidence how they would sustain local partnerships as part of the bidding process. There will also be significant scope for the VCS to deliver front-line rehabilitation services and to form genuine partnerships to enter the competition process.

29. Examples of good practice in involving the voluntary and community sector in the provision of resettlement and through the gate services include the work of RECOOP mentioned above. For example at

HMP Leyhill they have developed the Lobster Pot, a centre for men over 50 in the prison, providing a "one stop shop" for information and advice on a range of subjects relevant to the release and resettlement of older offenders.

30. Following an open competition in 2011, NOMS awarded a grant to RECOOP to build on their work in the South West by improving the capacity of prisons, probation trusts and voluntary sector organisations across England and Wales in working with older offenders. The grant funding runs until March 2014 and has allowed RECOOP to employ a number of regional consultants who are helping to set up interventions and build the capacity and skills necessary to meet the needs of older offenders in custody and the community. They are engaging prisons and probation trusts to identify the needs of both service providers and offenders, to raise awareness of the issues and begin to form lasting partnerships between NOMS providers and the voluntary sector. This will facilitate a range of interventions at local level, including information and advice; low level social care and advocacy; health and wellbeing promotion; staff awareness; and older prisoner forums. As part of this project RECOOP has developed their website to include a members' area that provides a range of resources for professionals working with older offenders.

The effectiveness of arrangements for resettlement of older prisoners

31. There are no specific arrangements for the resettlement of older prisoners: as with all prisoners, we respond to individual needs on a case-by-case basis.

32. We monitor outcomes to ensure fairness and work to understand and address any differential outcomes that are revealed by the data. The data presented in the NOMS Equalities Annual Report 2011–12 suggests a mixed picture in terms of resettlement outcomes for older offenders when compared with those for younger offenders.

33. In terms of total successful order and licence completions, the picture is a positive one. Whilst 76.3% of all offenders achieve a successful termination, this rises to 90.1% for those aged 50–59 and 88.6% for those aged 60 and over.

34. This is not repeated, however when we look at successful outcomes for accommodation, which were recorded for 88.1% of all offenders, compared to 83.1% of those aged 50–59 and 84.8% of those aged 60 and over. Similarly, successful employment outcomes were recorded for 25.4% of all offenders, compared to 23.8% of those aged 50–59 and 12.7% of those aged 60 and over (although in view of the state pension age it is perhaps no surprise that this last figure is so much lower).

35. By contrast, HDC is granted to 27.4% of all eligible prisoners, but 37.4% of those aged 50–59 and 34.1% of those aged 60 and over.

36. More work is needed to understand these figures: the offence type and sentence length profiles of the older prisoner population are very different from that of the population in general, and is likely to explain at least some of the differences.

37. RECOOP are working to build capacity across custody and the community, and their work is helping us better to understand the specific resettlement needs of older prisoners and to provide relevant materials for prisoners themselves and for the staff working with them.

38. The "Transforming Rehabilitation" consultation referred to above describes the Government's proposals to improve resettlement provision more generally by competing services in the community, incentivising providers to reduce reoffending and extending rehabilitative services to offenders released from short custodial sentences. We believe that these proposals will improve outcomes for all, including for older offenders.

Whether the treatment of older prisoners complies with equality and human rights legislation

39. As described above, PSI 32/2011, Ensuring Equality sets out the framework for the management of equalities issues in prison establishments. It sets out the policy approach and lists some key mandatory actions designed to ensure legal compliance. It is accompanied by guidance that sets out the characteristics of a person that are protected by the Equality Act 2010 and the conduct that is not allowed in relation to these characteristics, and explains the duties which the Act imposes on staff, including those relating to age.

40. Governors are required to ensure that a full range of management information on equalities issues is analysed and used to produce a local equality action plan. Progress must be tracked and an update report must be submitted regularly for discussion by the Senior Management Team, copied to the Deputy Director of Custody, and published to stakeholders including prisoners.

41. Governors must ensure that prisoners and other stakeholders, particularly those from minority groups, are consulted and involved appropriately in the management of equalities issues. In many prisons this includes the use of older prisoner representatives, and in some there are older prisoner forums, facilitated in a range of ways, including by staff, prisoners and voluntary sector groups such as RECOOP and Age UK.

42. The NOMS Equalities Annual Report provides data on a number of outcomes for older offenders (some of which has been used elsewhere in this evidence), and we are continuing to broaden the range of reporting, in line with our equalities objective around equalities monitoring data.

Whether a national strategy for the treatment of older prisoners should be established; and if so what it should contain

43. The Government does not consider the establishment of a national strategy for older prisoners to be the best way of proceeding. The equalities policy described above already makes clear that the particular needs of individual offenders must be identified and addressed. The differences within the group of older offenders (across the other protected characteristics in the equalities legislation, as well as in terms of offence type, sentence length and other factors) are wide and it is not possible to generalise about what their needs are as a group.

44. The various guidance and good practice documents described above are available to ensure that the needs of individuals are addressed, and we are monitoring key outcomes to ensure that any differences for older prisoners are identified, explored, and where necessary addressed.

45. The Department of Health proposals described above will bring significant improvements in the provision of social care for prisoners that will be of benefit to many older prisoners and the Transforming Rehabilitation proposals will provide more flexible and efficient services for them on release. We are committed also to continuing work specifically on older prisoner issues through the partnership with RECOOP that we are using to build capacity across the system, and through ongoing work with stakeholders through the Older People in Prisons Forum. We are, however, not convinced that a national strategy is necessary or would be the most effective way of taking this work forward.

March 2013

Written submission from Age UK

Introduction

1. As at June 2011, there were 8,125 prisoners aged 50 and over in England and Wales, including 2,811 aged 60 and over. This group makes up 11% of the total prison population. Older prisoners are the fastest-growing section of the prison population. The number of sentenced prisoners aged 60 and over rose, for example, by 119% between 1999 and 2009, yet none of the systems within the prison service are designed with older prisoners in mind.

2. There are a number of reasons for this growth, but a significant cause is the increase in the proportion of the sentenced prison population serving indeterminate sentences (life sentences and indeterminate public protection sentences) from 9% in 1995 to 18% in 2010. It follows that the majority of these will have been imprisoned for serious offences and no one should be in any doubt about the need to protect the public from those convicted of such crimes where appropriate. For example, 40% of men in prison aged over 50 have been convicted of sex offences. The next highest offence among older prisoners is violence against the person (26%) followed by drug offences (12%) (PRT Bromley Briefing December 2010).

3. Estimates of future prison numbers vary widely. By the end of June 2017 the demand for prison spaces is projected to be between 83,100 and 94,800. We can expect a significant proportion of these to be older prisoners, since there is no indication that the trend will be anything other than upwards.

4. Age UK supports a national body, the Older People in Prison Forum, to bring together interested parties from the statutory and voluntary sector. Some local Age UKs work closely with the prison service in partnership with health and social services and other voluntary organisations, including the Prison Reform Trust, Nacro, Action for Prisoners' Families, FaithAction, Independent Monitoring Boards, Restore 50plus, RECOOP, the Royal British Legion, SSAFA, and Combat Stress.

5. Through Older Prisoners' Forums, local Age UKs can help older people in prison to play an active role in improving the quality of the prison regime, to the benefit of the Prison Service as well as older prisoners themselves, and in support of successful rehabilitation and resettlement post release. Age UK has published a document advising commissioners on the services for older prisoners and older ex-offenders available from Age UK and local Age Uks.[i]

Definition of Older Prisoners

6. According to its terms of reference, the Justice Select Committee, for the purposes of this inquiry, proposes to define older prisoners as those aged 60 and over. This may on the face of it, seem logical, but it fails to take into account evidence that many prisoners in their 50s and over have a physical health status ten years greater than their contemporaries in the community.[ii] Age UK, among other organisations working in this area use 50+ as the definition of an older prisoner. We therefore think that the Committee should widen its remit to ensure important evidence is not excluded.

The Mental and Physical Health and Social Care of Older Prisoners

7. There is no explicit Prison Service Instruction (PSI) or Order (PSO) that supports effective commissioning for older people in prison. Older people in prison commonly suffer poor mental and physical health, but prison

staff in general lack training in the rights and needs of older people. Only a few prisons (eg HMP Downview) have developed their own older offenders policy and the recent Green Paper, Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders, made no mention of older prisoners.

The Effectiveness with which the Health and Social Care needs of Older Prisoners are met

8. Older people in prison should receive the same level of basic social and health care support as those not in prison and guidance should be developed and disseminated to Resettlement Teams outlining best practice and responsibilities in resettling older prisoners, including pensions advice, housing, and accessing healthcare. A report by Her Majesty's Inspectorate of prisons in 2008[iii] raised grave concerns that the social care needs, in particular, of older and disabled prisoners were not planned or provided for after release. Legislation clearly states there is a duty to provide healthcare to prisoners, but it is ambiguous when it comes to social care provision. Prisoners are not explicitly included or excluded from a local authority's duty of care, but in practice this ambiguity means many authorities do not extend their services to older people in prison. Statutory responsibilities should be clarified so that local authorities have a clear duty to provide in-prison social care.

9. Prison and health care professionals also need support to deliver high quality end of life care to prisoners, particularly if those approaching death are to be able to make genuine choices about how they are cared for in the last months of their life. Being in prison should not negate the right to a dignified death, both for the individual and their families. As the average age of the prison population rises—it is inevitable that the number of natural deaths in custody will also increase; a strategy to ensure these deaths are properly managed is urgently needed.

10. Older women prisoners may have quite specific needs, particularly around health care issues. It is important that women do not avoid seeking treatment in prison because of anxiety about how their request will be met, or possible indignities that they may suffer in diagnosis. Studies have shown that the potential humiliation of being handcuffed and of being strip-searched when moving to and from hospital prevented many women from seeking vital medical treatment.[iv] The lack of facilities and inadequate care can lead to a lack of understanding about age-related illnesses so that they are not catered for or even acknowledged. The discontinuation of medication is problematic for women, having unforeseen and unacknowledged side effects.

The Most Appropriate Environment and Regime for Older Prisoners

11. Older prisoners have different needs that should be reflected in their prison accommodation. According to NACRO, many older prisoners wish to remain in a mainstream wing environment, with access to all the available resources, and they should be supported in doing this, but with the option of having quiet spaces, wings and cells.[v] Simple environmental adaptations should also be considered and the creation of facilities with enhanced resources for accommodating older prisoners who may have mobility or other support needs. Resource mapping should be carried out at local and regional level to support moves to a more flexible regime for older prisoners.

12. With recent changes in UK legislation affecting the statutory retirement age, it is likely to be the case that many older prisoners will still choose to work, but others may not be able to do so (perhaps because of a health condition) and prison authorities will need to provide the opportunity for older inmates to take up alternative activities.

The Effectiveness of Training given to Prison Staff to Deal with Older Prisoners

13. Specific training for prison staff members in how to care for older people in prison is essential. Many of those for whom they are responsible will have impairment of sight, hearing, memory and the slowing of movement and mental responsiveness, all of which can make their needs quite distinct from those in the general prison population.

14. The 2008 HMIP also reported that there was a "complete lack of staff training in identifying the signs of mental health problems among the elderly." This is especially worrying, as evidence of the health needs of older prisoners has been available for more than 10 years.[vi] Recent research by Staffordshire University,[vii] for example, revealed that 48% of older people in four prisons had at least one diagnosable mental health condition, excluding personality disorder. Most had some kind of physical health problem. Finally, the HMIP Annual Report 2007–08 revealed few prisons have a designated nurse for older prisoners. "Older prisoners in England and Wales' HM Inspectorate of Prisons (2008)."

The Role of the Voluntary and Community Sector and Private Sector

15. Voluntary sector agencies have a key role to play in improving the lives of older prisoners both inside and outside prison; there are excellent examples of the third sector providing support services, advocacy, information and advice and signposting to prisoners, amongst others. But greater opportunities need to be given to the third sector to provide these and other services to older prisoners. For example, they could be brought in to advise on developing plans for special accommodation for older prisoners, setting up forums for older prisoners, and ensuring that older prisoners receive information and advice about the issues that are of concern to them.

Effectiveness of Arrangements for Resettlement of Older Prisoners

16. Resettlement programmes tend to be designed to meet the needs of younger people, which means that older prisoners suffer age discrimination. Many older prisoners experience problems related to housing and pensions/income on release from prison. These problems are often closely linked—and self-perpetuating. A significant number will have lost their homes—or will find it difficult to find affordable accommodation; resettlement grants are not adequate to pay for housing. In addition, many prisoners will not previously have been able to claim a pension.

17. It is therefore vital that older prisoners are able to access effective advice, support and signposting services both inside and outside of prison. Ensuring that older prisoners have access to appropriate accommodation on release should be a priority for prison resettlement/probation teams and local authority/housing association housing officers.

18. Many older prisoners find the resettlement process unsatisfactory in terms of the support and guidance they are given and the blame for this tends to fall on the probation service. They in turn admit that the service, particularly inside jails can be patchy,[viii] but suggest this is due to insufficient resources and those that are available being allocated according to the perceived risk to the public. Most older prisoners are deemed to be a low risk while still locked up and only as their release date nears are their needs addressed. They are also generally less assertive than their younger counterparts and do not request information, or at least do not do so repeatedly if it is not forthcoming.[ix]

19. Therefore probation staff need to take account of the particular needs of older prisoners in terms of their resettlement and support prior to release and ensure they are not overlooked. They should ensure all the relevant information is made available and that it is fully understood.

Equality and Human Rights Legislation

20. The Equality Act 2010 is a comprehensive unification of previous strands of discrimination law and new provisions. It prohibits various types of unlawful discrimination where that discrimination is "because of" a protected characteristic. Protected characteristics include disability and age.

21. The Public Sector Equality Duty sets out how a public authority must in the exercise of its functions have "due regard" to the need to:

- eliminate conduct prohibited under the Act;
- advance equality of opportunity between those with a protected characteristic and others; and
- foster good relations between those with a protected characteristic and others.

22. There are many aspects of prison life to which the Act and the Duty might be applied, including reception and induction, employment and education and skills, healthcare, adjudications, complaints, visits and correspondence, transfers and resettlement. For example, often little or no attempt is made to obtain a prisoner's GP, hospital, social services or previous medical records. Similarly, the initial assessment on arrival is still occasionally not done at all, or where it is, the standard is variable.[x]

23. The area of most concern however is older prisoners with disabilities. In its 2009 thematic report, HMIP concluded that provision for disabled prisoners remained variable across the prison estate and that disabled prisoners considered that they had a worse prison experience across all areas of prison life. It suggested that HM Prison Service still had "*a considerable amount of work*" to ensure that they fulfilled their duties towards disabled prisoners under the Disability Discrimination Act/Equality Act 2010.

24. The two main areas of practical concern for disabled prisoners are the identification and reporting of disabilities and the assessment and addressing of disability needs. There is a Prison Service Instruction covering this: PSI 32/2011, states "*Governors must consider whether prison policies and practices, the built environment, or lack of auxiliary aids and services could put a disabled prisoner at a substantial disadvantage and if so must make reasonable adjustments to avoid the disadvantage*" (paragraph 8.2)

25. Despite this the thematic report concluded that prisons have struggled to provide disabled prisoners with full access to facilities and activities, as disability needs are not adequately assessed/addressed. The two key barriers to meeting the needs of disabled people are lack of coordination between healthcare and social care in prisons and confusion over responsibility for and funding of, social care in prisons.

A National Strategy for the Treatment of Older Prisoners

26. It is important that the needs of older prisoners are recognised by those employed to care and rehabilitate them; at the same time, support for those who are released is equally as important, particularly if we are to prevent reoffending. It is hard to understand, even in a time of austerity, why a minimum level of resource has not been made available for this purpose and in particular why there remains no national strategy for older prisoners, supported by mandatory national and local standards.

27. A national strategy, while necessary, must also reflect the diversity of older prisoners and their different needs. As set out above, the definition of an older prisoner should be anyone who is 50 or over, which covers

a significant age demographic. Many, but not all older prisoners will have health issues, either mainstream conditions or ones resulting from lifestyle choices or substance abuse that commenced in prison itself. There are many organisations representing prisoners who could contribute to the development of such a strategy and we hope that Government consults widely as part of the process.

An Example of Good Practice

28. HMP Norwich is a category-B local prison for men aged 18 and over, which serves the courts of Norwich and Suffolk. Ten% of the prison's population are over the age of 50. The prison's most recent health needs assessment has identified that this small but significant older prisoners' population is in danger of being "lost" within the younger prisoners' needs.

29. To address the needs of older prisoners, HMP Norwich has established a partnership with NHS Norfolk, Revolving Doors Agency and Age UK Norwich. This aims to:

- improve social contact and mutual support between and with older prisoners by using volunteers as well as Age UK Norwich staff to run social engagement sessions and regular forums;
- contribute to improving and maintaining good mental health among prisoners, and especially older prisoners;
- provide information, advice and liaison support to older prisoners concerning life and opportunities after release; and
- provide onward referral to appropriate specialist support services to enable ex-prisoners to maintain wellbeing and to reduce further contact with the criminal justice system.

30. Age UK Norwich, together with the then staff at the older lifers' Nelson unit (L Wing), had been running a pilot project to support less able older prisoners with volunteer visitors. Unlike a normal befriending service, the volunteers visited in a small group. This was both to provide support to each other and also to encourage the development of social interaction between clients.

31. The first year evaluation, after the visits had been going for a few months, indicated that the majority of prisoners had benefitted in some way from the project. Staff and volunteers believed the visits to be beneficial in a number of ways. Indicators of improved wellbeing included improvements in older prisoners' welcome and willingness to chat, their contribution in suggesting activities and their engagement in activities.

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