# Submission to the Justice Select Committee's inquiry into the Ageing Prison Population

by Her Majesty's Chief Inspector of Prisons

## Introduction

1. We welcome the opportunity to submit a response to the Justice Select Committee's inquiry into the ageing prison population.

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 and include reporting on the conditions for and treatment of those in prisons. The inspection of health and social care services in prisons in England is jointly undertaken by HMI Prisons and the Care Quality Commission (CQC).[1]

3. HMI Prisons is a member of the UK's National Preventive Mechanism (NPM), the body established to comply with the UK's obligations arising from the UN Optional Protocol to the Convention Against Torture. The NPM's focus is to prevent torture and ill-treatment in places of detention.

4. HMI Prisons inspects all adult prisons against our *Expectations*, which contain four healthy prisons tests: safety, respect, purposeful activity and rehabilitation and release planning.[2] Our Expectations include that the specific needs of older prisoners will be met.[3]

5. Our response is drawn from our inspection evidence over recent years, including from prisons that have a high proportion of prisoners aged 50 and over in their population,[4] and from our joint thematic with CQC, *Social care in prisons in England and Wales*.[5] We also carried out an analysis of our surveys of prisoners undertaken since September 2017 to highlight the different

[1] HMI Prisons leads on ensuring that health and social care services meet expectations, including considering issues such as the impact of the prison regime and environment on care. CQC leads on ensuring that health and social care providers comply with registration and regulated activity regulations, determining if it is necessary to take regulatory action.

[2] *Expectations: Criteria for assessing the treatment of and conditions for men in prisons*, available at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/; and *Expectations: Criteria for assessing the treatment of and conditions for women in prison*, available at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/02/final-womens-expectation_web-09-14-2.pdf. The fourth healthy prison test in the women's estate is referred to as resettlement.

[3] See *Expectations: Criteria for assessing the treatment of and conditions for men in prisons*, expectation 48; and *Expectations: Criteria for assessing the treatment of and conditions for women in prison*, expectation 22 in respect.

[4] Based on population demographic figures provided to HIM Prisons by each prison at the time of inspection. HMI Prisons uses the age of 50 as a benchmark for defining 'old age' in prisons. For an explanation of why, see HMI Prisons and CQC, *Social care in prisons in England and Wales,* October 2018, available at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/10/Social-care-thematic-2018-web.pdf, p. 13.

[5] We note that some of our inspection and thematic findings do not separate the impact of certain issues on the older prison population. For example, inspection reports may note how the prison responded to mobility issues for prisoners generally without making a specific finding about older prisoners in particular.

perceptions of men and women in the 50 and over age group and of men in the 70 and over age group.[6]

6. Our response provides information which we hope will assist the Committee in examining questions two to seven and question nine of its terms of reference.

# Accommodation and living conditions

7. We expect all prisoners to live in a clean and decent environment, which is in a good state of repair and fit for purpose. In our surveys, those over 50, particularly men, were generally much more positive than their younger counterparts when answering questions about their accommodation, such as whether the wings were normally clean, and whether they were sufficiently quiet to sleep at night. In these surveys, 44% of men aged 50 and over and 56% of men aged 70 and over stated that they had a disability (compared to 34% under 50 and 35% under 70). The same proportion of women aged 50 and over as aged under 50 told us they considered themselves to have a disability (45%).

8. Our inspections found that a number of prisons where older prisoners made up 20% or more of their population had taken some action to meet their accommodation needs by designating specific wings to house them.[7] We generally found these wings to be quieter and calmer. For example, the Samforde unit at Hollesley Bay was quiet and calm with its own garden and exercise room and houseblock 14 at Northumberland provided an excellent environment for older men, with a constructive culture of mutual support. At Frankland, a spur had been designated for the over 55s; this was a calmer environment with a more therapeutic feel. Older prisoners sometimes shared wings with those with health and social care needs.

9. Many of the wings assigned to older prisoners and those with health and social care needs were sensibly located on ground floor level. However, enhanced units were often on higher floors and at New Hall we found that those with mobility issues had difficulty accessing the enhanced floor at Larch House (although a lift had been ordered). Prisoners at Larch House also pointed out the lack of adapted facilities for those with disabilities – there were only two adapted cells and two baths. At Dartmoor we noted the need to "make a considerable investment to make the environment viable for men with disabilities. Cell entrances were too narrow and had not been adapted, so men had to leave their walkers on the landing and ask for help to get inside."

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

11. Many prisons made use of peer supporters (often referred to as buddies) to provide assistance to those with mobility issues and/or who needed help with day-to-day tasks. These peer support schemes were sometimes well developed, with prisoners paid to undertake the role full-time and provided with clear job descriptions, training, and supervision. For example, at Frankland, buddies had received training in dementia care and end of life care and support. At Whatton, there was a succession plan for peer supporter social care advocates to ensure

[6] The number of survey responses from women over 70 was too small to draw comparisons from.
[7] Of a sample of 25 prisons with a population of older prisoners above 20%, 12 had designated accommodation.

continuity of provision if carers were transferred. However, we found instances of peer support that were informal and/or relied on the goodwill of fellow prisoners. For example, at Full Sutton, we found that assistance with personal care and daily needs depended too much on the helpfulness of fellow prisoners acting as volunteer buddies. At Swaleside, the carer scheme had been discontinued because some prisoner carers had taken advantage of their position to exploit others; prison officers were instead assisting those who needed help with the basic tasks of daily living. Disability orderlies at Leyhill had job descriptions and were committed to their roles but had no training or supervision and were inappropriately expected to be the first point of contact in an emergency.

# Purposeful activity and regime

12. We expect prisoners to have regular and predictable time out of cell sufficient to promote rehabilitation and mental well-being. All prisoners should be able to engage in education, skills or work activities that promote positive personal development and behaviour. Those prisoners who are retired should be unlocked during the day and provided with suitable activities.

13. In our surveys, more men and women 50 and over than their younger counterparts reported spending 10 or more hours out their cell on a typical weekday (for men, 14% compared to 9%; for women, 30% compared to 16%). Eight per cent of men aged 70 and over reported spending 10 or more hours out of their cell.[8] However, we continue to find too many establishments where retired prisoners are locked up during the core day. For example, at Manchester, older prisoners who did not work were not routinely unlocked during the day and we spoke with an 88-year-old who was only unlocked for about two hours most days. At Rye Hill, those who were retired and did not attend education could frequently spend more than 22 hours in their cell each day.

14. Prisoners of retirement age should be able to elect to continue to work. All women at East Sutton Park, including those who were retired, were involved in work or education. At Northumberland, specific activities were carefully identified by workshop instructors to enable older prisoners and those with physical disabilities to participate. At the diversity centre at Dartmoor older prisoners took part in a variety of activities, including repairing wheelchairs and producing bird boxes from recycled wood for the Devon Wildlife Trust, but this was only available to 30 men at a time and was often closed as staff were redeployed.

15. Those prisoners who no longer work should be provided with sufficient appropriate activities. However, we found too many prisons that offered older prisoners little to do. For example, at Wakefield, it was positive that older prisoners were unlocked during the core day, but there was often little to engage these prisoners and very few areas for them to socialise.

16. We have seen some positive examples of activities being provided specifically for older prisoners. Many prisons offered some specific physical education provision and some had introduced physical activities more suited to less mobile prisoners such as walking football, seated aerobics and bowls. We also saw examples of spaces for older prisoners to socialise and engage in recreation. At Standford Hill, the lounge in the chapel was reserved for older prisoners, and Moorland had created a number of 'retreats' for older prisoners on some of the house blocks. The activity centre at Rye Hill offered older prisoners opportunities for art and model making, lessons in IT and horticulture, as well as a reading area and board games to promote literacy and numeracy. At Leyhill, the 'Lobster Pot' was a drop-in centre for over 50s that provided a range of activities and was also used to host well-being events, health screenings and to raise awareness of issues such as dementia.

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[8] These figures were not statistically significant.

17. Retired prisoners should not be disadvantaged because they are not working. At Stafford, some older and retired prisoners felt that they did not have the opportunity to reach the enhanced level of the incentives and earned privileges (IEP) scheme because they did not undertake responsible paid jobs in the prison. However, the prison was working to broaden the range of avenues to the enhanced level. At New Hall, we noted that it was unfair that rates of pay for retired prisoners (and disabled and pregnant prisoners) were lower than for those on the basic level of the IEP scheme.

# Health and social care

18. Inspections have found that the provision of health services to older prisoners has improved although improvements are not consistent across the prison estate. We found that older prisoners mostly had good access to annual health checks and age appropriate health screenings, including for dementia. However, there were some gaps at some establishments, for example at Gartree, prisoners were not able to consistently access health checks, disease prevention and screening programmes. At Wakefield, inspectors found a prisoner who had waited several months for a dementia assessment due to a lack of community services. Health conditions were managed reasonably well within long term and mental health provisions. Medicines were mostly received on time, however, there was inadequate pharmacist access at many sites for prisoners to discuss their medication.

19. Some prisons provided specialist clinics for older prisoners, such as outreach visits to the wings by a GP and a nurse at Littlehey. At Norwich, 24-hour nursing and social care packages were offered for a mainly older group of prisoners with chronic health conditions. A number of prisons had age-appropriate optometry and podiatry services and access to audiology for eye, foot and hearing aids respectively, but waiting times varied. For example, at Manchester, older prisoners had been waiting for appointments for a dedicated clinic for at least 12 weeks. We were concerned about the lack of adequate specialist care for older prisoners at some sites.

20. We expect that prisoners with social care needs will be identified and receive assessment, care packages, adaptations and advocacy services that continue after release or transfer.[9] Together with CQC, we carried out thematic work examining the provision of social care in prisons in England and Wales, publishing our findings in *Social care in prisons in England and Wales* in October 2018. That thematic work and inspections found inconsistencies in the provision of social care across the prison estate, including in the identification of social care needs. At Stafford, prisoners' social care needs were identified and suitable care packages were provided; two prisoners were receiving personal care from community carers, aided by trained prisoner carers, and prisoners who needed equipment and adaptations were referred to local community services. At Norwich, there was a clear social care referral process and staff were trained to identify prisoners with potential needs. However, as noted in our thematic report, at some prisons the responsibility for the identification of social care needs was with healthcare staff as part of a secondary screening but not all prisoners received that screening. In addition, some prisons had little awareness of social care and we observed that one prison had received a small number of self-referrals for social care but none of them had been appropriately reviewed to assess whether they met the threshold for care. They had not therefore been passed on to the local authority for further assessment. Delays in identifying care needs caused frustration for prisoners, especially if they had been in receipt of care in the community, and also led to some prisoners being inappropriately located within a prison.

[9] Local authorities became responsible for assessing and meeting the social care needs of adult prisoners in April 2015, when the Care Act 2014 came into force.

21. We have found variation in the time taken by local authorities to carry out assessments. In our thematic report, we noted that we were pleased to see that the longest delay at Littlehey was 10 days. However, we also found delays of up to five months. When there are delays in completing assessments, prisoner's immediate social care needs should still be met. However, interim arrangements are only appropriate if they meet all of prisoner's needs and do not require healthcare staff to provide social care during the delay. At Wakefield, we found that assessments were often delayed for more than three months but this was mitigated slightly by care being provided before assessments had been completed and the availability of living aids.

22. The quality of social care provided varied. At Bure, we found that care plans consistently met individual need, equipment was provided and adaptations were made to cells where appropriate. The care plans we inspected at Thameside were detailed and person-centred, and care staff kept detailed daily records about the care provided. In contrast, at Gartree, prisoners' needs were not consistently met because their care plans were not up to date as a result of inadequate oversight of referrals, assessments and reviews. Inspectors were concerned that a prisoner with social care needs at Whitemoor did not always receive the care he needed, as council social carers could not enter Whitemoor regularly to provide social care. In our thematic, we noted that there were some problems transferring prisoners receiving social care to another prison, including not providing the receiving prison with sufficient information to enable it to continue the care package. We noted that one prison was unable to transfer two prisoners because the receiving prison could not provide the necessary social care. In another case, a prisoner was transferred and then returned to the sending establishment a week later because the receiving prison could not provide the necessary care.

23. We found that the arrangements for palliative and end of life care were improving across prisons. Some prisons had palliative care facilities, most of which were located in the inpatient unit. For example, at Leyhill, a palliative care suite provided excellent end-of-life facilities for two prisoners and their families in individual rooms. Inspectors found some prisons collaborated effectively with health providers and palliative care services in the community to strengthen delivery of care. For example, at Usk, a robust palliative and end of life pathway was being jointly developed by the prison, the local health board and relevant community partners. At Dartmoor, Macmillan nurses and hospice staff ensured prisoners received high quality palliative care to the standard that was provided in the community. Both Wakefield and Norwich had achieved external accreditation in recognition of their palliative care provision. However, palliative care remained underdeveloped at some prisons. At Stafford, there was no lead member of staff for palliative and end of life care, and at Gartree, arrangements for end-of-life care were poor; prisoners believed to have palliative care needs were not clearly identified, and their care plans were inadequate.

# Resettlement

24. We expect each prisoner's individual resettlement needs to be identified and addressed, with planning for release starting from their arrival at the establishment. As part of this, we consider whether prisons have a strategy for rehabilitation and release planning that is underpinned by a needs analysis of their population. On a number of inspections, we have found that those strategies did not sufficiently consider the needs of particular groups, including older people. For example, at Dartmoor, we noted that the new reducing reoffending strategy "needed to be more specific to HMP Dartmoor and the type of prisoners held there, such as older men, those serving long sentences and sexual offenders."

25. In terms of further support for release, such as finding accommodation, and assistance with finance and healthcare, both women and men aged 50 and over reported similar levels of support to those under 50. Thirty-four per cent of men aged 50 and over and 59% of women

aged 50 and over reported they were receiving help with finding accommodation and 28% of men aged 50 and over and 40% of women aged 50 and over were receiving help to sort out social care support on release. At Stafford, we found advisers helping older prisoners to acquire volunteering work before release. In contrast at Stocken, the terms of the contract with a charity assisting with resettlement needs only permitted the charity to set up bank accounts for prisoners of working age. Despite the efforts of senior managers to resolve this issue, two retired prisoners had been unable to get help to set up bank accounts in order to receive their pensions. In relation to social care, in our thematic report we noted some good practice to ensure social care needs were met on release. However, we also found examples where this had not occurred and where there was poor communication between the prison and the local authority, including delays in providing discharge notifications to the local authority.

## Strategy for the treatment of older prisoners

26. On a number of inspections, we have noted that work to support older prisoners would benefit from a clear local strategy underpinned by needs analysis. At Hull, there was no strategy to meet the specific needs of older and retired prisoners and no social activities or groups for these prisoners (other than two dedicated gym sessions each week). In other establishments, although there was some good work taking place, this was not underpinned by a strategy. For example, at North Sea Camp, we noted "[o]lder men spoke positively about the activity sessions run by gym and equality staff. They were particularly useful for men who might otherwise have spent nearly all day in their room because they were retired or unfit for work. However, they only happened twice a week and did not take place during our inspection. The policy document for older prisoners was not based on a needs assessment and we thought some older men, particularly those with disabilities, needed more support." In contrast, at Elmley, we noted that "[t]he prison had conducted a needs analysis of this prisoner group and outlined how their needs would be met. Provision included more time unlocked for retired prisoners, high-backed chairs and access to age-specific physical education."

27. In addition to local strategies at establishment level, we have also previously noted the need for a clear strategy at national level in relation to social care, recognising that meeting the needs of particular cohorts of prisoners as the prison population changes requires consideration across the prison estate and across government. In our social care thematic, we recommended that "[t]he Secretary of State for Justice should lead coordination of cross-governmental work to develop a strategy for delivering social care in prisons in England and Wales." Cross-governmental work could consider issues such as those highlighted above in relation to transfers, suitability of accommodation and ensuring timely communication between prisons and external agencies. This recommendation was rejected on the basis that local authorities are responsible for providing social care in prisons, rather than the Ministry of Justice or Her Majesty's Prison and Probation Service.[10] We have also called for a strategy on older prisoners more broadly. Such a strategy could take into account factors such as their needs, how best to ensure continuity of care, prison population management and the physical infrastructure, including whether high levels of physical security are necessary for infirm prisoners.

## Conclusion

28. Our inspections have found examples of good work being undertaken to meet the needs of older prisoners in some prisons, including accommodation wings specifically for older

[10] The action plan is available at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/10/Action-Plan-Social-Care-in-Prisons.pdf.

prisoners, the use of dedicated spaces to provide a range of age-appropriate and purposeful activities and some well-managed peer support. However, we continue to find too many retired prisoners who are locked up during the core day or unlocked with little to do. We also find inconsistencies in the provision of social care. Needs-based strategies at both a local and national level would assist to provide better support to older prisoners.

29. I hope that you find this information useful and should you require anything further, please do not hesitate to contact me.

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