HOUSE OF COMMONS

Justice Committee

Oral evidence: Ageing prison population, HC 304

Tuesday 12 May 2020

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Watch the meeting

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

Questions 87 - 176

Witnesses

I: Steve Bradford, Prison Group Director for the Women's Estate; Graham Beck, Governor, HMP Wymott; and Alan Cropper, Lead Manager for work with older prisoners, HMP Wymott.

II: Lucy Frazer QC MP, Minister of State for Justice; Dr Jo Farrar, Chief Executive, HM Prison and Probation Service; and Kate Davies CBE, Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres at NHS England and NHS Improvement.

Examination of witnesses

Witnesses: Steve Bradford, Graham Beck and Alan Cropper.

Chair: Good afternoon, and welcome to this meeting of the Justice Committee. This is the final session of our inquiry into the ageing prison population. We have two panels of witnesses today. I welcome our first panel and will ask them to introduce themselves as we start the evidence.

First of all, Members have to give declarations of any relevant interests. I am a non-practising barrister and a consultant to a law firm. I welcome Richard Burgon and Paula Barker, new members of the Committee who have joined us, replacing Ellie Reeves and Marie Rimmer.

Richard Burgon: Prior to being a Member of Parliament, I was a practising solicitor.

Paula Barker: Nothing to declare.

Andy Slaughter: I was a barrister, but I am not practising at the moment.

James Daly: I am a practising solicitor and a partner in a high street firm of solicitors.

Dr Mullan: Nothing to declare, Chair.

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

Maria Eagle: I am a non-practising solicitor.

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

Rob Butler: Until the election, I was a non-executive director of HM Prison and Probation Service, and the magistrate member of the Sentencing Council.

Q87 **Chair:** Let us turn to our first panel. Would you introduce yourselves, please?

Steve Bradford: My name is Steve Bradford. I am currently the prison group director for the women's estate.

Graham Beck: My name is Graham Beck. I am the governor of Her Majesty's Prison Wymott in Lancashire.

Alan Cropper: My name is Alan Cropper. I am the lead manager for work with older prisoners at HMP Wymott in Lancashire.

Q88 **Chair:** Thank you all for coming to give evidence to us. I will start with a specific question to you, Mr Beck. We are looking at the broad issue around the challenges that confront the system with older prisoners. Obviously, the coronavirus outbreak and the particular vulnerabilities of older people, wherever they are, throw that into sharper focus in the prison estate. When the chief executive of HMPPS, Jo Farrar, gave evidence before us in the last week or so, she mentioned that there had been a particular issue over a weekend at your prison, HMP Wymott. Could you help us with that? What

happened and how did you deal with it? How was it managed and what challenges did you face? What can we learn from that?

Graham Beck: We were informed of imminent changes to be made to the prison regime late on 23 March, following the Prime Minister's announcement. We had a further detailed briefing in a phone call at 7.15 the next morning.

Our initial actions were to set up our own local command structure and to ensure our local communications and planning were well co-ordinated. We put in place an operational governor, administrative support and a rota of attendance to cover our seven-day-a-week programme. We report daily to our operational command. We took forward six areas of action. We immediately implemented a restricted regime, which offers prisoners 45 minutes per day in groups of 20 or fewer, during which they can access showers, phones to call home and open air for exercise.

Secondly, we implemented social distancing measures as required, by excluding non-essential staff such as our teaching colleagues. We brought in queueing systems and rules for attendance in offices, and we changed our food delivery routine to avoid prisoners having to queue for food at mealtimes. We brought in systems to ensure that our essential services continued, such as food preparation, delivery of prisoner canteen goods, laundry and waste management. All those things took some adjustment over the initial couple of weeks.

We implemented hygiene rules, such as handwashing on entry to the prison. Handwashing stations were placed in key areas, such as the entrance to our older prisoners' unit. We also became the Lancashire hub for PPE. We managed our efforts through our group director, managing delivery and distribution of PPE for the five prisons in our area. We experienced some concerns over the supply chain for PPE early in that period, but they were resolved as we moved along.

Fourthly, we began a long process of cohorting our prisoners. The incident you are referring to, Chair, was around our expression of concern that, through our health colleagues, we were given a list, at that time, of 200 prisoners who were believed to be especially vulnerable to coronavirus. They were men who had been identified as requiring a flu jab in our previous planning exercises. Further information came through to indicate that that was an underestimate and that almost 400 of our prisoners would be classified as either vulnerable or extremely vulnerable if infected with coronavirus. At that point, we expressed our concern around the vulnerability of those people. There is a longer story to tell about our cohorting arrangements, which I think have been very successful, to protect those men.

Early in the proceedings, we were able to gain access through our healthcare provider to a small number of swab tests. We discovered that one of the men with some symptoms, who was resident on a small enhanced unit holding 40 prisoners, was indeed positive for coronavirus.

That, and the fact there were some other men with symptoms at the time, identified us as an outbreak site. We gained the assistance and support of a Public Health England-led outbreak control team.

We took some early decisions to isolate areas, so J wing was immediately treated as a family, in essence, with 14 days' isolation. Our healthcare team briefed prisoners on what was required of them early on the Saturday morning to make sure they understood their responsibilities.

I am delighted to say that the outbreak of one on J wing was contained. We were able to put in place some very good shielding arrangements early, and perhaps we were very lucky that the wing is held in its own compound, with no obvious access to other areas. We were able to control staff access, limiting access to a very small number of staff.

The particular prisoner recovered reasonably well. Between the Wednesday of that week, when he had his first symptoms, through to the Saturday when we found his positive test, he had already shown some signs of recovery. Within the next few days, he did very well; he came out of his condition and became well. I am pleased to report that there have been no further cases at all since that weekend on J wing, which we have continued to hold in a shielding position.

Q89 **Chair:** Is J wing one of the wings where you hold a particular number of older offenders?

Graham Beck: No, it is not designed for older men. It is a lower security unit. In fact, it was put in place as temporary additional accommodation in the 1990s. It is a low-security type unit. It is an enhanced unit.

Q90 **Chair:** I get it. That is why it is called enhanced. Carry on.

Graham Beck: Having got through that weekend, we initiated additional regime activities to enable our prisoners to remain engaged while in their cells. I should have mentioned that Wymott is an unusual prison in that we have a very large number of non-cellular accommodation. Those are rooms where prisoners share access to toilets and showers. They are not, effectively, locked in at night, so there are risk-assessed prisoners in those areas.

Where we had prisoners in cells, we brought in in-cell education packs. Our teachers provided education packs that are still delivered weekly. We set out some nationally supplied occupation for time in cells—colouring-in books, quizzes and that sort of thing. Our chaplaincy immediately prepared appropriate prayer packs for all religions; we are very pleased with the swift response there. We were able to increase our number of TV channels available to the men. Our staff went about organising quizzes, and even an art competition, to keep the men occupied. We used the services of in-cell TV provider, Wayout TV, to offer religious programming and other information to our men.

As mentioned, from that point on, we had regular phone conferences with the outbreak control team, who advised on many aspects of our strategy. They helped us through some very difficult decisions about moving prisoners—when it is appropriate to move prisoners and to correctly allocate them to rooms, whether they are cellular or non-cellular.

Q91 **Chair:** You have about 1,100 prisoners in Wymott.

Graham Beck: Yes. Normally our capacity is 1,170. Due to issues of moving prisoners between cells to ensure we have people in the right places, we were able to reduce our operational capacity. Right now, it is 1,020 prisoners.

Q92 **Chair:** In terms of the age profile, how many would be over 60? That is the benchmark figure that has been taken for older prisoners for these purposes.

Graham Beck: There are 170 prisoners over 60 years of age; 65 over 70; 11 over 80; and one over 90 years of age.

Q93 **Chair:** You have in particular quite a number of longer-term prisoners.

Graham Beck: We do. We are a long-term training prison. We specialise in people serving life sentences, indeterminate public protection sentences and other long sentences.

Q94 **Chair:** That is why we are particularly interested in how you coped, given that profile. We understand that the matter is now under control and hopefully dealt with. We all owe you and your staff the public's thanks for the extra mile you all went in order to deal with what was a very threatening situation. We are grateful to you, and I hope you will pass that back to all your staff.

Graham Beck: Thank you very much.

Q95 **Chair:** May I ask our other witnesses generally how staff and prisoners are responding to the effects, particularly older prisoners, but more broadly as well? There are restrictions, and that can potentially create stresses and strains, both on prisoners and on staff. What is the general feeling across the estate, and what in particular is the position as far as older prisoners are concerned?

Steve Bradford: As far as the women's estate is concerned, when the emergency was first declared it is fair to say that the first two to three weeks were quite hectic. After that, things began to settle down as the residents and staff began to get used to the new rules of the game, so to speak.

The women, particularly the more mature ones, were mostly concerned about not having access to children and grandchildren. As you will appreciate, in the women's estate closeness to home and family ties is a massive part of what we try to focus on and get right. The initial concerns were much less to do with lack of access to education or training facilities

and much more to do with when they were next going to see their loved ones. In the women's estate, the visits are predominantly around access to children and grandchildren, and less to do with seeing male partners. The initial concerns were what we were going to do about lack of access to visits. We compensated by allowing additional phone credits and providing facilities for emergency compassionate calls via iPads.

Q96 **Chair:** Any particular issue with older prisoners?

Steve Bradford: Most of the older women, in our experience, were more concerned with the particular vulnerabilities linked to their age. About 15% of our population today are aged over 50. It is not a hugely significant amount. Indeed, the majority of our elderly women are between the ages of 50 and 60, which is not considered elderly by NHS colleagues. While we in the Prison Service would consider them elderly, our NHS and social care colleagues were less concerned, because they do not share the same definition as we do of an elderly person. With most of the mature women, the concern was about how we could keep them safe because of the vulnerability due to their age.

Q97 **Chair:** Do you find that is an issue that arises in dealing with older prisoners generally, leave aside the current covid business—the fact that the NHS and social care definitions are different from those that operate in prison?

Steve Bradford: Yes, sometimes it can be an issue. For example, in some cases, our women may be 50 years of age, but in biological terms they are considerably older because of some of the abuses they have been through in their life. Biologically, their age can be quite advanced. We find that is not always something our NHS or social care partners fully appreciate in the same way as we do.

Q98 **Chair:** Thank you. Mr Cropper?

Alan Cropper: What we started to do early on, when the lockdown started, was to consult regularly with our prisoner council. I and another residential governor met wing reps every two days to inform them of the process and to take their views on board about what would work for them in the scenario. We consulted every two days and took on board what they wanted, and told them what was likely to be expected. Their concerns were around visits especially and healthcare. We tried to put in place as much as we could to keep them informed during every step of the process.

They asked for extra TV channels. They asked for extra phone credit for family contact. All of that was put in place. We put a bigger staff ratio on the wings, so there were no staff visible when prisoners were unlocked. They had a regime. We put an extra wing manager on each wing as well, so there was always a wing manager that prisoners could speak to.

We feel that staff/prisoner relationships are really good at the moment at Wymott. That is through lots of communication and regular meetings with the wing reps. We have another wing rep meeting planned tomorrow with

just six of them, with social distancing, to see what the general feelings are now and if there is anything we need to be aware of. Staff communication was paramount at the start of the process.

Q99 **Richard Burgon:** This is to all the witnesses. Graham, Alan and Steve, your explanations and insights have been really useful, but could you expand further for the Committee? How are you ensuring that prisoners with chronic health conditions continue to be monitored and receive treatment during the lockdown, particularly if such prisoners are old or are being shielded? That is presenting difficulties and challenges outside the prison estate in the rest of society, and it must be in the estate as well.

Graham Beck: I am happy to answer that from Wymott's point of view. Our healthcare manager has a register of all our prisoners with long-term conditions. We now have a practice nurse and a community matron. They have changed their practice and go out to attend prisoners on the wings for their annual review, rather than calling them up to our healthcare centre. That is a small adjustment that our healthcare team has been able to make. All our prisoners with long-term conditions can request time with those nursing staff if required between reviews.

Prisoners requiring time with consultants can now do so via telephone consultations. Those take place in our healthcare centre. I am told that they are going very well, with local consultants in hospitals able to conduct some of their reviews in that way to reduce our demand on escorts. If the hospital requires prisoners to go to the hospital, we can facilitate escorts as per our usual arrangements. We have had to put in place some adjustments for safety on return, with the risk of a prisoner returning with infection, and of course appropriate PPE for prisoners and our staff is now available if necessary. We have implemented a protocol for transport and isolation on return as part of our management plan.

We have found that in the past week or so we are sending out more men for routine appointments, for scans, MRIs and X-rays associated with their long-term conditions. As far as we can, we believe we have good care in place for the men with long-term conditions.

Q100 **Chair:** Any additions?

Steve Bradford: In the women's estate, there is a similar position. Women who have been identified as either extremely vulnerable or vulnerable have been picked up through our in-house healthcare providers, who have taken the necessary steps to increase the level of care or welfare checks that are being delivered. One example is that where we still have pregnant women in custody we are keeping a very close eye on them, particularly those who are in their third trimester, so that we make sure they are getting the necessary protection and extra care that they should be afforded.

Q101 **John Howell:** I want to touch on the question of how you define who is an older person. I cannot remember which of you spoke about people being older than the number of their years because of the abuse they have had

to suffer. What is the cut-off point, both for men and for women, for saying when they are old?

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

Q102 **John Howell:** Steve, do you want to add to that?

Steve Bradford: We work on the assumption that if you are aged 50 or over in the Prison Service, or in my case in the women's estate, we treat you as a resident who is potentially more vulnerable and keep a closer eye on you.

Difficulty sometimes arises when we think that somebody should be accessing a particular screening programme, such as a bowel cancer screening programme. The NHS policy will normally dictate that that is done by age category, and that is sometimes where we get tension between the two services. Sometimes, we struggle to persuade NHS colleagues that a person should be referred to a screening programme without having to go through a particular care pathway or be referred to a consultant. Sometimes, the biological age or the physical symptoms do not always fit with the age category that we refer to as an elderly or vulnerable patient.

Q103 **John Howell:** I want to turn to the characteristics and behaviour that differentiate the older prisoner from the younger prisoner. Can you start by giving me a feel for what those changes and characteristics in behaviour are?

Steve Bradford: Our more elderly women tend to want to try to opt for living or working in an area where there are more women in their own age group. They find it much more difficult coping with busy 19, 20 or 21-year-olds, who tend to be noisy and a little bit chaotic in their living or working environments. There is a natural tendency for the older residents to want to be among their own peer group and people who have similar interests, and where the general custodial experience is more sedate and less stressful for them.

We get the natural ageing process, where more of our elderly residents are hampered with mobility problems or have other age-related health conditions. They want a bit more privacy and dignity in the way we look after them. They tend to fall into two camps: the young, energetic and vibrant residents, and the more mature ones, who prefer a quieter life.

Q104 **John Howell:** Does it produce an operational challenge for the prison in trying to make sure that that is accommodated?

Steve Bradford: It can be an operational challenge, depending on the accommodation layout in the prisons. For some establishments, it is quite easy to designate certain parts of the accommodation for the more elderly residents, so we can group them together, and almost, to some degree, build a separate regime for them. If they are of a certain age, they do not have to go to work; they are essentially retired. Where we get the opportunity, we tend to try to group those residents together because they have common interests and common needs, although that depends on the numbers in each establishment and the type and nature of the accommodation on offer to the governor and the staff.

Q105 **John Howell:** Graham and Alan, do you want to add anything to my first question about the characteristics and behaviour differences between the young and the old?

Graham Beck: I agree with a lot of what Steve said. We find with the men that there are quite a few adjustments. They are a very varied group of people, and I would hate to stereotype an older man in prison as having particular characteristics, although Alan and I were speaking earlier and agreed that in general the older men are more co-operative and less aggressive than the younger men. They are better adjusted to institutional life. As Steve rightly said, they prefer a quieter regime, with a range of activities that keep them occupied and interested in a generally quieter environment.

I noted in my preparation for this that we observe some differences in men who are growing old in prison. We have men who have served 30 or 40 years in prison. Their institutional behaviour is different from those who are serving possibly shorter sentences or have newly arrived. We have seen that particularly with the increase in the number of men serving sentences for historical sexual offences alongside life sentence prisoners who are serving very long sentences. There are some obvious adjustments and institutionalisation issues that we have to consider in our management of those cases.

Finally, we find among the men some very disturbing cases of social isolation, where our prisoners have lost family members over the years and have nobody who visits them socially. Essentially, they become part of the Wymott family, with relationships with prisoners and staff their sole source of social contact. We have been able to use that to help build a community spirit among our older prisoner groups by holding them on two wings in our establishment, as Steve described. We use the family atmosphere there to develop a regime that is fairly rich and enables people to live a reasonably fulfilled life.

Q106 **John Howell:** Alan, going on to the operational challenges, we have heard about some from Steve, but what are the other operational challenges that come with housing older people?

Alan Cropper: Some of the operational challenges are with the health needs of older prisoners. Obviously, they are more dependent on healthcare, physically and mentally. We are creating two communities on B wing lower landings and I wing. We have carers based on I wing. We have the same cohort of staff who have volunteered to work on those units.

It is slightly different from normal prison officer work. As Graham said, there is less aggression and self-harm. It is more to do with social needs and being part of a community. Graham touched on the fact that there are lots of men with us who get no visits whatsoever. Through our visits liaison officer, we get those men together a couple of times a year in the chapel area where they can all meet each other. That is from both sides of the prison—the VP side and the cat C mainstream side. The prisoners can meet and socialise with each other. We do that twice a year, and it is very popular.

Those are the different characteristics that the older prisoners bring. There is more one-to-one work than normal prison officer work. Staff express a desire to work on those units and they have a really close staff/prisoner relationship. They become part of one big family.

Q107 **Miss Dines:** I have two questions. The first one is to Mr Beck and Mr Cropper. What sort of accommodation do you provide for older prisoners or others with disabilities and poor mobility at Wymott? The second question is a wider one to all the witnesses. How easy is it for the prison authorities to provide reasonable adjustments for the disabled or those with limited mobility? Are there any funding issues? Is it prison design? A prison in my Derbyshire Dales constituency, Sudbury, has design issues. Those are my two questions.

Graham Beck: We have 11 wings at Wymott housing our different prisoners. The original wings were built in 1970 and the prison opened in 1979. Those wings are not very well designed, or were not initially designed, for some of the challenges we face with our older prisoner group. For example, there are lots of stairs, and our old wings are on two landings. There were no ramps and no consideration of movement between wings, or very little consideration, at the time of building.

We have had to make adaptations over the years. The wing Mr Cropper referred to, which is our main social care centre, is I wing, which was originally the prison's induction wing. It has a range of different accommodation, some of which is cellular and some of which is non-cellular where, effectively, the men have access to their own locks on their doors. We have had to work hard to bring in some adjustments over the years.

Last year, we had the fortunate experience of bringing in additional provisions to enable us to comply with fire regulations. We now have better emergency lighting. We have runway-style lighting so that we can identify routes of access. We have been able to modify our emergency evacuation procedures to fit those requirements.

The rooms are generally quite small, so adjustments like fitting hoists for lifting prisoners who are immobile are very difficult for us. As mentioned, some of the accommodation is less than desirable, but we do our best to keep it clean, tidy, hygienic and reasonable. I do not know if Alan wants to add anything. His day job is managing those areas in our prison.

Alan Cropper: On the main side of the prison, we have some disabled cells where prisoners live. They have wheelchair access and their own showers, so we have the facility for prisoners with wheelchairs to live in the main side of the prison.

Q108 **Miss Dines:** The second question was about funding. Are there any funding difficulties or specific design difficulties? That is a question for other witnesses.

Steve Bradford: In the women's estate, the main issue is the fact that the majority of our prisons, or the 10 prisons I have responsibility for, do not tend to be the new type of buildings. To a degree, we are constrained by the fact that some of our accommodation is not necessarily disability friendly.

However, it is not always about providing a room that can accommodate a wheelchair. Generally speaking, we are pretty good and successful at making reasonable adjustments for our women. When the women come in through reception, we do a proper health screening process for them. At that point, if there is a recognised disability identified, normally the staff working in our equalities department do a proper risk assessment to identify the nature of the disability and what we can do to support them. It can be as simple as providing hearing aids or spectacles, or walking frames provided by our colleagues in social services.

In the main, we are quite successful in making those reasonable adjustments. What is more difficult is when we get women brought into custody who are clearly very unwell through long-term health conditions and rely on a much higher level of healthcare support. For example, they can be completely oxygen dependent or bedbound—confined to a bed for 24 hours a day. We tend to struggle more with making reasonable adjustments when they arrive in prison with really complex disabilities, as opposed to the day-to-day ones.

As each year goes by, and we are not getting the benefit of brand-new buildings that deliberately incorporate a facility for disabled prisoners, we are quite successful in bidding for capital moneys. In each of our prisons, we are improving the rate and ratio of disability cells, or cells where we can provide palliative care, for example. We are in quite a good position. Ideally, it would be better in terms of the physical infrastructure, but we are making reasonable progress in that area.

Q109 **Chair:** How many women do you get coming into prison with those very complex disabilities or conditions?

Steve Bradford: I would not say it is an everyday, or even a weekly or monthly, occurrence, but every now and again we get women sent to prison, quite often for very short periods on remand. In the women's estate, we do not have large amounts of healthcare in-patient provision. We struggle in local prisons to accept the women. Our healthcare colleagues tell us that we do not always have the physical capacity to provide the level of care needed. That presents us with a problem.

Quite often as well, for whatever reason, some of the courts use prisons as a place of safety. If a woman is very poorly with a long-term condition, even a life-threatening condition, or if women are seriously mentally ill, we find that they get sent to us, maybe only for a few weeks, as a place of safety because there is no alternative provision available in the community.

Graham Beck: I agree with Steve's observation. We sometimes have the opposite end of the story on resettlement of prisoners. We have looked after people with lots of adjustments, lots of additional social care and skilled work with charities and the third sector, but when it comes to releasing the prisoner it is very difficult to find a safe environment in which to put them. Occasionally, it takes us considerable time to negotiate a safe release because there are community partners who are reluctant to take on some of those demands and expectations. There are challenges for us at both ends, on entry and on exit.

Q110 **Maria Eagle:** I would like to thank Mr Bradford for pointing out that disability goes beyond mobility issues. While I understand, with the prison estate being the way it is and much of it as old as it is, that the mobility issues are very much to the fore, many disabilities are in fact invisible and cannot be seen just by looking.

To what extent, when people come into prison, in both the women's and the men's estate, are officers able to pick up disabilities? People do not always declare their disability. Quite often the disability can have contributed to their offending behaviour, and it is not always admitted. It is seen as a source of shame or something to be hidden.

To what extent can you pick up the disability? You cannot make reasonable adjustments if you do not know that there is a problem. I imagine there may be some differences between the women's and the men's estate, but perhaps Mr Bradford could tackle that question.

Steve Bradford: Our experience in the women's estate is that women want to tell us that they have a disability because they want help with it. Perhaps unlike in parts of the male estate, the women are always happy to talk to us. Our healthcare screening tool in reception is designed to ask those questions and to identify any obvious disability, or a disability that is not obvious. In our experience, certainly with women, we do not find that there are many women who want to hide it from us.

The more difficult cases to assess are where we have women coming in with complex cognitive issues or mental health problems and where, for whatever reason, their communication skills are poor, or they are in such

a poor state of mental health in any case that they are unable to participate. Invariably, we find that, if we do not initially successfully screen on reception, the other women will find out that the person has a problem and will tell staff about it. We tend to find out one way or another if somebody has a disability and needs help. Our in-house equalities teams are trained to pick up on that and make the necessary referral.

Graham Beck: I agree entirely. I am sorry if I led anyone to believe that we thought that disability was all about mobility. One of the things I would pick up on from Steve is that we are fortunate, as a long-term prison, to have quite a lot of history to work with when our men arrive. We also have a very long tradition of good partnership working with our healthcare providers and social care workers.

I would not want to leave out the voluntary sector. We have a very close working relationship with Age Concern, the Alzheimer's Society and other third sector organisations who are really helpful in training our staff and making our partnerships work effectively, helping our prisoners to explain their difficulties and enabling us to adjust.

Q111 **Maria Eagle:** Do you find that you have the capacity to access capital money to make changes to the prison estate? I know how bad it is. I was a regular visitor 10 years ago, and the last time I went to Styal it looked pretty much like it did when I used to visit more regularly. I wonder whether or not you can get access to the funding needed to make your estate fit for purpose in dealing with disability adjustments.

Graham Beck: We prepare bids all the time. We are always preparing for the opportunity to invest in our estate. It seems strange to say this, but my prison is only 40 years old, yet it needs additional help in terms of its maintenance and design.

We have been fortunate over the past few years to get enough capital investment. It is usually in quite small areas, if I am honest, but we have been able to bring in some adjustments, such as handles for people in bathrooms and in some other areas. That is a very low level of investment and is quite easily done. We have brought in safes in cells to help with things like keeping possession of medication. They are small things but they make a big difference to our men's lives.

We would always like more money. It would be ridiculous to think that wouldn't help us, but we have been fortunate to bring in some investments that are very useful.

Q112 **Rob Butler:** Mr Cropper, I would like to talk a little bit about regime. You and your colleagues have touched on it a little bit. Could you take half a step back and explain exactly what your role is as the lead manager for older prisoners? Is it full-time? Did you have a special degree of training? Could you talk us through that?

Alan Cropper: I am a residential governor on a residential unit. Two of those units are the older prisoners unit. I also manage a segregation unit,

as well as safety and equalities. I have had a wide range of experience in all those areas.

I have not done any specific training regarding older prisoners, but I have sought lots of advice from our partner agencies such as Lancashire social care; the RECOOP charity, which comes in and trains some prisoners to be buddies; and Age Concern. We do a lot of work with the Salvation Army, who have a CAMEO centre, which is voluntary, where a lot of older men do basic tasks like cooking, letter writing and board games. I have involved myself a lot with the demographics of the older prisoner.

The regime for the older prisoners is that no prisoners are left locked in the cells. If they are not working, they are all—*[Inaudible]*—open all day. All the cells are open. They have a recreation area. There are board games. There are fish tanks, where we breed fish and sell them to a local pet shop.

The regime for older prisoners is slightly different from mainstream prisoners. If mainstream prisoners are not working, some of them will be locked up during the day. We try to make it more of a community than a prison setting. There are good staff/prisoner relationships with the older prisoners, and it seems to work well at the moment.

Q113 **Rob Butler:** I am glad you mentioned the CAMEO centre. I remember visiting there a while ago, and to me it felt a bit like a daycare centre within a prison. It was a very different atmosphere, which was bespoke and appropriate for the older men there. Do you think that is something that could be shared and done in other establishments?

Alan Cropper: Definitely. It is such a success at Wymott. The older prisoners feel safe when they go to the CAMEO centre. They are among friends and they meet prisoners from other parts of the jail whom they would not usually meet. It is well managed by the Salvation Army. There are no operational officers in there. We have had no alarm bells in the centre that I can remember, and it is well received. For me, it is a real success story for Wymott, and it would be great across the whole prison estate.

Q114 **Rob Butler:** Your governor picked up on the difficulties sometimes of finding accommodation for older men when they are released. Presumably, there is a corresponding challenge in terms of regime. Many of them, when they are released, are of retirement age. They are not going to go and get a job, or even seek a job. How do you prepare for what they are going to do with themselves once they are released, if they are released?

Alan Cropper: We work closely with the offender supervisor and offender management units. If they go into a hostel setting, we invite the hostel in to explain to the prisoners exactly what they will get when they are released. We try to involve all the partner agencies as much as possible for any prisoners who are due for release to explain to them the environment they are going out to.

Mr Beck mentioned that we have had some difficulties in getting prisoners released because it has taken a bit of time for the local authorities to come and assist us. We try to involve them at every step of the way with an outside offender manager and an inside offender supervisor. We try to involve as many people as possible so that the gentlemen know what to expect when they get released outside.

Q115 **Rob Butler:** Mr Bradford, you touched a bit on the regime in women's prisons. Is there anything you want to add specifically about the regime for older women?

Steve Bradford: The elderly women in our estate tend to want to organise the things that they enjoy. Some of the third sector organisations come in, like the Women's Institute, Age UK, Age Concern and other voluntary sectors. We have baking classes and knitting circles, and we play bingo. They tend to go for the less energetic and quieter activities, rather than the full-on energetic classes that might be on offer elsewhere in the establishment.

Q116 **Rob Butler:** Given what we have heard, both about accommodation and regime, do you think that prison is the right place for elderly people, if I can use that term? Some have suggested that we might need to consider something like a secure care home type of environment, or a secure old people's home. What do you think of that?

Steve Bradford: Inevitably, there will always be a need to incarcerate some of our elderly citizens, purely linked to the fact that some of the offending that they commit is quite serious; but I believe, in line with the female offender strategy, that many of the elderly women who are in prison could be better accommodated in the community, either with suitable preventive support to stop them getting into trouble in the first place or with better community sentences. Probably two thirds of all the elderly women in our prisons are in for short-term sentences for low-level crimes, when actually they pose very little or no risk to the public. I would be a keen supporter of that sort of alternative proposition.

Q117 **Rob Butler:** Mr Beck, what about elderly men?

Graham Beck: *[Inaudible]* but I have two things to add. One is not to characterise our prisoners as being entirely vulnerable old men. Some of them are also very dangerous old men. We have had some cases recently of people we have been trying to resettle through MAPPA—multi-agency public protection arrangements—who are vulnerable, have social care needs and disabilities, but bundled among those is also a significant risk to the public. They present a particular challenge for the right accommodation at the right stage of their sentence and release arrangements.

My second point is that I have been at Wymott for two years and have been surprised at the number of elderly men who are a long time over their tariff. They have been in prison for longer than I would have expected. I have one prisoner who has served 42 years and whose tariff expired in 1998. There is a small group of people like that. They are people who are

perhaps a little bit lost in the system. There are things to be considered around parole arrangements and risk management for that particular cohort as well.

Q118 **Rob Butler:** This is for both of you; I think you alluded to it, Mr Beck. Some people might think that the regimes you are describing are a little bit too cosy and comfortable. After all, these are normally people who have committed serious offences that warrant a custodial sentence. What reassurance would you provide to victims that it is indeed still prison?

Graham Beck: It is still prison. We hold people in as safe, secure and decent arrangements as we possibly can for their own wellbeing and safety, and ours. Of course, like everything else in our policy, we look to do our best to rehabilitate prisoners for life after release, but the grim reality for a small proportion of our population is that they are very unlikely ever to get released.

We have very sophisticated end-of-life care planning now. There is careful consideration of compassionate release requests. Hopefully, it is a decent and respectable environment, but at the end of the day, it is life without liberty. I hope that I would be able to stand in front of any victim of any crime and say, "This is still prison, and it is as respectable and decent as it can be," for the obvious reasons.

One of the things we have done is to capitalise on a spirit of hope for our men, even in cases like the one I mentioned. Amazingly, after 42 years in prison, he still has some spirit about him and an optimism that he will one day be released from prison. I would like to be able to say to any victim of crime or member of the public that that will only happen when safe arrangements are in place for him, and he will not commit any further crimes, particularly of the nature he committed previously.

Q119 **Rob Butler:** Mr Bradford, is there anything you want to add?

Steve Bradford: In the women's estate, a fairly significant chunk of our women who arrive in custody have some experience or history of quite serious trauma, whether that be domestic abuse, sexual abuse or drug abuse. When they arrive, they are looking for and in need of help. We invest a lot of time in trying to help those women overcome their trauma and give them hope for the future that there is a better way of living.

While we might offer knitting or baking classes, that is only a small part of it during the day. A lot of the women are taking part in quite difficult programmes designed to tackle, challenge and deal with their histories of trauma. It is not a walk in the park for them, by any stretch of the imagination. I would not want anybody to think that that was the case.

Q120 **Dr Mullan:** I want to pick up on some of the comments from Rob. Mr Bradford you spoke about the lower sentences. I think you would accept that in very many instances those people have been subject to lower level non-custodial action, yet there has not been a change in their patterns of behaviour. We have to be clear that shorter sentences are not a first

approach; they tend to be used by judges when they feel that non-custodial action has not worked.

Steve Bradford: Yes, I agree. In many instances in the women's estate, the women are repeat offenders. They return to custody time after time because, for whatever reason, we have been unable to break the cycle of offending. The classic example is that women come into prison, and we spend several weeks or months cleaning them up and ridding them of their drug addiction, but then, on release, they return to their old haunts where they used to live. They are back in chaotic environments, and without the support that is always necessary, they quickly regress and commit offences again. They find it really hard to break that cycle on their own.

Q121 **Dr Mullan:** You are absolutely right to identify the cycle there, but it is important that we acknowledge the complexity around short sentences. It is not that they do not serve a purpose; they have a purpose along a chain of action that we take.

Steve Bradford: They do.

Q122 **Paula Barker:** Could we talk about older prisoners who have served longer sentences? We know only too well that they often become institutionalised and struggle to reintegrate into society. For some of them, it might be around technology and the use of IT, or how to apply for employment or housing benefit and basic things around how to access health and social care.

What specific support do you think older prisoners need before being released? More importantly, what do they actually get? I would like to understand the differences between the female and the male estate, if I can.

Graham Beck: I am happy to respond on resettlement needs. We are probably fortunate at Wymott. We are not within the normal range, in that we very often have a very long planning window for people's release. We are able to use that time well to engage with our education partners, probation services and local authorities. As Mr Cropper mentioned earlier, in virtually every case we are able to take a multidisciplinary approach.

Very often, for our older population employment is not the outcome we are seeking, but we are able to assess things like training needs and institutional needs. In an ideal world, our men will transfer to an open prison, a category D prison, and have a period of adjustment when they can go out on temporary licence and learn about life in the community again. I was previously governor of an open prison and was very proud of that arrangement when it worked well because it enabled people to take a graduated approach to release.

Sadly, for our population that is not always applicable or available, because the men do not reach the risk threshold for a category D prison but are released into the community. At our most extreme, we are talking about people who go to very specialist provision. We were looking at the case

this morning of a 46-year-old man who has served 23 years in custody, 17 years at Wymott. We have had plenty of time to get to know his specific needs, and our staff have had plenty of time to consider the adjustments that he would have to make in his life, or the people around him, to enable him to live in society.

You have highlighted very carefully one weakness, which is access to modern developments like IT. Although we have a virtual campus available within our education curriculum, as most prisons do, there is probably more we could do to help people understand the complexities of IT in the modern world. The past few weeks have particularly highlighted the issue for us all. IT provision is something I would like to develop further.

Q123 **Paula Barker:** You have just touched on the fact that some prisoners will go to a category D prison and learn how to reintegrate into society, but that is not always the case. For prisoners who do not get released to a category D prison, do you see any differences between those who are directly released from Wymott, for example, and those who go first to a category D prison, in terms of reoffending levels or anything like that?

Graham Beck: I could not quote any statistics on reoffending, but from my own experience I think that the people who have to be released from a training prison like ours are the more difficult and complex cases. They would not do well in the intermediate world of a category D prison. The protection and mitigation for us is a much better multi-agency approach and a long planning window to enable us to put good arrangements in place.

Perhaps Alan could comment on a couple of cases he has been personally involved in, where I feel we should be very proud of bringing the right partners around the table to make sure that we do—

Chair: We have to keep it fairly brief because we have to move on to the second panel.

Alan Cropper: It is about what Mr Beck touched on before. We released a gentleman with severe learning difficulties. He had served 23 years in custody. A lot of people said that he would not survive outside, but there was a Parole Board directive for release.

We had six months to plan and to bring people in from a certain trust to help work with him and explain what was expected of him when he got outside. The wing staff all worked with him and prepared him for that release. Even on his day of release, wing staff came in on their day off just to see him off. He was with the Langley House Trust. The feedback we are getting from them is that he has managed to settle in his own self-contained living environment with a carer on site. He is managing fine and effectively. He was one of the more complex men and we had some concerns about releasing him into the community, but—touch wood—up to now it has worked very well. We have some complex men who would struggle outside after so long in prison.

Q124 **Paula Barker:** Would Mr Bradford talk about the women, please?

Steve Bradford: Certainly. In the women's estate, in terms of work, we have good links with the hotel, retail and entertainment industries. We are quite successful at supporting women back into work. Many of our women worry about going through the gate without having proper support for their addiction, but again, we are quite successful at making sure that they have addiction services support, whether for drink, drugs or indeed mental health, and that is all linked to the relevant pathways.

Our biggest problem in women's prisons is finding suitable accommodation for the women. Understandably, many of our women, because of their history of abuse, do not want to return to where they were living prior to coming into custody. It puts them back in their old environment where they are going to be a victim of domestic abuse or be tempted back into drug taking. Many of our women opt not to elect to volunteer for consideration for our voluntary early release schemes because they feel safer living in a women's prison than having to return home to live in their old conditions. Our biggest challenge is suitable accommodation.

Q125 **Andy Slaughter:** You covered this a little bit in terms of your relations with health and social care providers outside. Let me ask a little more about that. What is your relationship with local authorities in terms of social care and delivering on social care, given that you use different criteria?

Graham Beck: I am happy to comment from a local point of view. We have been through an interesting two years at Wymott. Our healthcare provision was recommissioned a few years ago. When I arrived in 2018, I found in my initial stay that it was not achieving the standards that were required, and that created some risk. That was then confirmed in a CQC inspection, which raised some serious concerns about patient safety.

From there, we were able to ask the NHS to commission an improvement process, which took over a year. The prison and our partners around the table in all aspects of care were directly involved in that process, including Lancashire County Council and their social care department.

I met the head of adult social care personally in 2018. From that point, we put in place new arrangements for social care delivery in the prison. They have been superb partners through the process. We feel very confident now that we have a robust arrangement for assessment of the social care need and the delivery of need to those men, supported by a buddy system, with clear boundaries for who does what.

The CQC followed up its inspection with a secondary inspection, which gave a very positive report about the improvements that our healthcare and social care partners had made. The NHS has now recommissioned our healthcare service, with a new contract that started in April, and has taken learning from that improvement exercise. It has really improved our healthcare and social care services at Wymott. I am very confident that it will deliver an excellent service.

Q126 **Andy Slaughter:** I have two other questions. First, what is the training like for your own staff in terms of identifying healthcare needs, particularly in relation to something like dementia? Do you feel that is being picked up quickly enough?

The other question is about older prisoners needing to go outside the prison for medical appointments. The stats that we have seen—this is general rather than particular to you—show that one in three of those is missed, which is ridiculous. For every three booked appointments, one of them is cancelled for some reason. Could any of you respond to both of those?

Graham Beck: In terms of training, I mentioned our multidisciplinary approach. We are very reliant on our mental and physical health partners in their screening to make sure we are aware of dementia and its impact. We provide awareness training for prison officers and over the past couple of years have engaged with the Alzheimer's Society. We are moving towards dementia-friendly status in our prison as well, which has given us an enhanced layer of awareness.

We have been able to make lots of adjustments for people. Alan mentioned to me earlier that there was a prisoner who had dementia on one of our units. We put a photograph on his door so that he knew that was his home. These small adjustments are appreciated by the men.

Q127 **Chair:** Do you think he actually knows where he is?

Alan Cropper: He is a young man of 42. He has Pick's dementia. There is a big picture of himself on his cell door, so he knows where his cell is. He will function normally through the day with the rest of the prisoners, but he will—

Q128 **Chair:** I am interested to know whether he knows he is in prison. That is the key bit.

Alan Cropper: Yes, he does know that he is in prison.

Q129 **Chair:** Do you get some prisoners who actually do not know where they are and do not realise they are in prison?

Alan Cropper: I am not aware of any person who does not know they are at Wymott, no.

Q130 **Chair:** Thank you. Sorry to interrupt, Mr Beck. Do carry on.

Graham Beck: On the escorts, we allocate six escorts for appointments per day with our healthcare provider, which is an agreed level of 30 per week. Every week, we monitor how many are missed through our fault and how many are cancelled by the hospitals. We try to drive down those figures to a performance—*[Inaudible.]*

Q131 **Chair:** We have a technical problem. Do you want to come in, Mr Bradford?

Steve Bradford: Going back to the question, I can talk from an England-wide perspective. Overall, the quality of the healthcare services is very

good, broadly speaking. Some parts of the women's estate are better than others, and that is down to the fact that we have different providers delivering health services in different parts of the country. The social care is also pretty good, and in most cases local authorities are complying with the requirements of the Care Act and taking an active role in their prisons.

The social care teams and the local authorities are, generally speaking, probably less engaged in prisons compared with health partners. Some of them have been almost a little bit reluctant to come to the party, so to speak, but, generally, the support over the last couple of years from local authorities and health providers has been very good.

In terms of hospital appointments, as Graham said, there is always a raft of reasons why they do not happen. Quite often it is because of operational difficulties on the day and we simply cannot find the staff to take the women out. Quite often, there are communication breakdowns between the relevant clinics in the hospitals and the prison's healthcare department. Things get lost in translation. Also, quite often, in our experience the women simply change their mind and do not want to bother going. They opt not to go, and of course we cannot compel them to attend their hospital appointments if they choose not to do so.

Q132 **Dr Mullan:** Graham, you mentioned the joint commissioning for improvement. As a Committee, we were looking more broadly at the issue of joint commissioning. I understand that in the past there was supposed to be an attempt to engage prisons in deciding what healthcare provision was for them locally. Do you and Steve feel that you are more broadly engaged, and had you been before this specific circumstance meant you were involved in an improvement programme?

Graham Beck: As Steve reflected, generally speaking, I have found our relationship with NHS England as commissioners and our providers to be pretty good. My experience at Wymott was that when I raised concerns on arrival there was a very quick response from NHS England. To be fair to them, the providers at the time acknowledged quickly some of the deficits in their system. There was very little resistance, which I found helpful.

In the re-procurement, NHS England were able to negotiate an early end to our contract with our providers, which we felt was helpful for our partnership working, and a dignified early end to that contract. We were actively involved in the procurement process. That included the marking of bids and the scoring of each of those processes.

In my experience of prisons, that was my best experience of a joined-up process, which even included from start to finish a service user—a low security prisoner who came to all the meetings. Personally, I can only say that I am very grateful for the support I have had from NHS England.

Steve Bradford: I broadly agree with Graham. Generally speaking, the level of co-operation and partnership is of a reasonably good standard overall.

Q133 **Dr Mullan:** I am asking specifically about commissioning and whether you are involved. What is the model? What do we want from the service?

Steve Bradford: The commissioning is divided between north and south as far as the NHS goes. From my perspective, I have a national overview. We have multiple NHS commissioners, some working in the north of England and some working in the south of England. The governance arrangements for that vary, and a lot of it is linked to NHS geographical commissioning arrangements. Broadly speaking, most of the involvement in the commissioning arrangements is done at local prison level.

Graham Beck: Could I add one thing? It is a very technical point. One thing I asked our healthcare commissioners to do was to make sure that we had a very robust health needs analysis for our population, recognising the huge variety of people we hold and the different stages of time and sentence. That investment was really worth while in driving the commissioning process forward.

Q134 **Dr Mullan:** There has been increasing use of remote medical appointments—video and telephone appointments—in the current crisis. Do you see a bigger role with that for you in the long term? Steve, I am particularly interested in what you said about some people not wanting to go. You might get a better success rate if they could just go along to a consultation on video or telephone in the prison.

Steve Bradford: That is right, in theory. To be honest, telemedicine has been around for quite a long time. When we try to advance that particular issue with NHS partners, we find that there is a reluctance on the part of some of the consultants who do not want to run a prison-specific clinic.

Chair: That is interesting.

Q135 **Dr Mullan:** Why is that? Could you expand on that slightly? What reasons are given?

Steve Bradford: I can only assume that there is reluctance on the part of the consultants to run a prison-led clinic because it would interfere with their normal clinic processes, where people are attending and come to see them in their own environment.

Q136 **Richard Burgon:** As we all know, there has been a real expansion for some time in the prison population at the higher age end. In the evidence presented so far, we have heard about specific cases of people with dementia, and how the staff and institutions are able to help them out on the estate.

I would be keen to hear people's opinions more generally—not just about Wymott but more broadly—on whether they think prison staff, who face a very challenging job in any event, receive sufficient training and guidance on recognising and managing age-specific healthcare issues such as dementia. We are all clear that prison officers are certainly not turnkeys; the demands on them are becoming greater and greater, so it is very

important for them to get adequate and good training, especially linked to the ageing population in prison. Do you think there is sufficient training and guidance in the estate across the board when it comes to dementia and other age-specific healthcare issues?

Steve Bradford: I am not at the moment familiar with exactly what is delivered as part of the prison officer foundation level training. There is some teaching around mental health—on the identification of symptoms, how they present and how they can be recognised. It is fair to say that we are certainly not turning out mental health nurses in the 10 to 12 weeks' training we give them.

More of that work, in my experience, is being done at local level where prison governors work with their own in-house health teams and mental health providers to deliver local in-house training and raising of awareness with their own staff. That is the more important part, to be fair.

Q137 **Chair:** Can Alan Cropper help us on that? You are working at that sort of level.

Alan Cropper: I have done some work at Wymott with the Autism Society and the Dementia Society. We have staff who may experience those difficulties at home and they want to learn more about it. We have staff who are dementia friends, so they know how to spot dementia and how to work with prisoners with dementia. Some staff have autism in their family, and they are keen to broaden their horizons. In general, I think the training could be better with regard to dementia and other mental health issues.

Dr Mullan: That is useful. Thank you.

Q138 **James Daly:** I have a two-part question for all the witnesses. How useful is the model for operational delivery concerning older prisoners? Do you think a national strategy for older prisoners is necessary?

Graham Beck: Obviously, we were involved in the development of the model for operational delivery and were delighted to have a couple of examples of our own practice quoted there. For us, it has been a real step change and has helped to bring learning across prisons that have a special interest in older prisoners, share good practice and give us some clear guidelines.

From a strategy point of view, I have been thinking as we have been talking today that prisons like ours become victims of our own success. We manage a vulnerable population very well, and then other prisons allocate those prisoners to us and we have an ever-expanding problem. Perhaps a strategy would be helpful in making sure that we have the right resources, training, staff and partnership arrangements in the right places to deal with those particularly dynamic changing population demographics.

Steve Bradford: I tend to agree with Graham. Given that, over recent years, our elderly population has increased substantially and has been our fastest-growing age group in prisons, we have become much more adept

at identifying and meeting the needs of our elderly residents. That has been supported by many of the inspectorate reports, which say that we are doing a much better job these days than we used to do.

In terms of a national strategy, I have an open mind. If we were to go for a national strategy, I would want to make sure that it was at least bespoke to the women's estate, where we focus on delivering a trauma-informed approach to dealing with women in custody. My other concern would be whether it would deliver the necessary outcomes we were looking for.

Alan Cropper: As Mr Beck said, Wymott is a victim of its own success. I get quite a lot of transfer requests from other prisons, asking me to take complex prisoners at Wymott. I think a lot of prisons think that we are just a facility for older prisoners, but we are not. We are a big, complex prison. There needs to be more work like the work we are doing at Wymott across the estate in general.

Q139 **Chair:** Any views on strategy?

Alan Cropper: I think a strategy would be good for older prisoners.

Q140 **Maria Eagle:** The female offender strategy always struck me as a bit of a shortened and cut-price version of Jean Corston's recommendations. I wonder whether the sort of provisions the strategy seeks to make in the female estate, dealing with female prisoners, have any lessons to teach that would be applicable to the male estate. We know that female offending, offending behaviour and length of sentence can be very different, but are there lessons that could cross over from what has been successful with female prisoners to help male prisoners, especially in the older age groups?

Steve Bradford: I think so. Some of our more elderly prisoners in the male estate would certainly benefit from some of the alternatives to custody, such as the small residential centres that we are proposing for female offenders. It is about getting to the point where we can get male offenders to access the support and help they need prior to them committing the offence. That is the key to reducing the reoffending trend. Yes, viable alternatives to custody for low-risk, low-level male offenders are something that could be looked at positively for male offenders.

Graham Beck: We are always keen to learn how we can develop our services. In the past, it is possible that older prisoners were a neglected group, but since the model for operational delivery was published in 2018 we have been able to learn from research and other advice. I would welcome a perspective from the women's estate and those recommendations for our population.

Chair: Thank you very much indeed. That is extremely helpful. Gentlemen, thank you all very much for your time and for the evidence that you have given us today. We are very grateful to you.

Witnesses: Lucy Frazer, Dr Jo Farrar and Kate Davies.

Q141 **Chair:** Welcome, Minister, Dr Farrar and Ms Davies. Thank you for your patience. We had quite a bit of ground to cover with the first panel.

Minister, I will come straight to you. We have already discussed this. The state has an obligation to deal with prisoners who are vulnerable because of chronic or serious health conditions at any time. The covid pandemic has made that starker in terms of its focus, and of course older prisoners are potentially particularly vulnerable in that field. What specific steps are being taken to monitor, treat and shield older prisoners?

Lucy Frazer: You are right to say that at this time we are very conscious of the impact of covid on the older population. We are taking a number of measures to protect the elderly vulnerable population. I would put them into three categories.

Chair, you mentioned shielding. That is one category. We are shielding the most vulnerable. We are also taking a number of measures within the estate itself—restricting transfers, social distancing, making sure that we stop visits and all those things. Then, of course, we have our compassionate release scheme as well.

As you mentioned shielding, perhaps I can briefly expand that. Every prison has a list of the extremely vulnerable in their prison. All of them are offered the opportunity to shield. Currently, 76% of sites have shielding units, and we hope to be at 100% by the end of May. What we are trying to do in those units, where possible, is to have different staff dealing with people on the unit to ensure that we do not have cross-contamination across the estate.

Q142 **Chair:** Can you help me as to how many older prisoners have been released through the compassionate release scheme?

Lucy Frazer: So far, five prisoners have been released under the scheme, and two of those fall within the older category.

Q143 **Chair:** That sounds like compassionate as opposed to the other scheme.

Lucy Frazer: Yes, that is on the compassionate scheme.

Q144 **Andy Slaughter:** Continuing on prisoner releases, we are interested in older prisoners, but could you put it in the context of overall numbers released? We are aware that during the covid episode there has been a decline in numbers in custody of at least 2,000 prisoners. I do not know whether that is because of less crime, or what the reason is. Is it fair to say that as a consequence of that you have taken your foot off the pedal in relation to other release schemes?

The last figure I saw for releases was on 1 May, which is now 12 days ago. That was 51 prisoners released, of which 30 were from the pregnant women cohort. That is against a target of several thousand. Could you let us know what is happening with that?

I know this is slightly off piste, but we were expecting the statutory instrument this afternoon, and although it is part of a different scheme—the increased tagging scheme—it would have released another 500 prisoners. We understand that has been cancelled or put back, again because numbers have fallen. Whereas we can see some logic in that fact, it seems bizarre given that we have so many prisoners sharing and such a continuing covid risk. That perhaps particularly applies to older and vulnerable prisoners. Could you deal with those issues?

Lucy Frazer: Absolutely. We are guided in the way we manage the prison estate at the moment very much by PHE. The advice that we received from PHE is that, in order to operate a safe system within our prisons, we should get headroom of around 5,000 to 5,500 spaces. That will enable us to fulfil the strategy that HMPPS have worked out with PHE. As I mentioned, part of that is the shielding strategy, and part of it is the compartmentalisation of people who need to isolate because they have symptoms. Also, we want to stop people coming into the estate, feeding the infection, so we reverse-cohort them and keep them in a separate area for 14 days so that they are not spreading the infection. PHE and HMPPS identified that to do that we needed to create capacity of around 5,500 spaces. We have made significant progress on that.

You mentioned the natural fall-away in releases compared with the incoming cases in relation to court. That has given us a little bit of headroom. We have been doing work in other ways as well. We have done a lot of work on remand, trying to get the cases of prisoners held on remand heard, so that if they had already been convicted but not sentenced, and we knew that their time had already been served, they were released. We have done a lot of different prospective work, which has given us headroom of around 3,000.

We believe that in the next few weeks we will get the additional 2,000 to 2,500 through the release scheme and the additional units that we are bringing on to the estate. You have heard us talk about the temporary units that we are bringing on to expand capacity. All those measures will allow us to operate a safe system. Although an important part of the scheme and of our strategy is the early release scheme, it is not the only part of the strategy.

You asked me about numbers, and I am happy to give you numbers. As of yesterday, we had 21 pregnant women released and 55 end-of-custody temporary releases—those under the early release scheme—in addition to the five that I mentioned on the compassionate side.

Q145 **Andy Slaughter:** That is very helpful, but it seems a missed opportunity. I appreciate that you may be getting some benefit that you had not anticipated, but you have 14,000 prisoners who could benefit from single cells. A month ago, there was a 4,000 target for early release, and other methods were being contemplated, including increased home tagging. I do not know if you can comment briefly on why that has been pushed back or dropped. Why aren't you taking advantage of that system to relieve

overcrowding more? It would obviously help lots of cohorts of prisoners, but it would help in a lot of other ways as well.

Lucy Frazer: We are very committed to the strategy we have set out in relation to making sure that we sentence people for the sentences that are handed down. You will remember that in April we brought in legislation to ensure that people serve their sentence. We are also interested in rehabilitation. HDC is part of the rehabilitation strategy. HDC is an existing scheme that works well. People are being released on HDC at the current time.

The numbers have changed significantly since we laid the legislation. As you mentioned, the number of people in prison sits at around 80,000, which has significantly dropped. That is a very different place from where we were. We are spending a lot of our energy and much of our time ensuring that we keep our prisons safe and deal with the immediate issue, which is covid.

Andy Slaughter: I will have one more try because I am not sure that addressed my question. I asked the Lord Chancellor exactly this question before Easter. I asked what the pace of release would be. He said, "Well, we've got a bank holiday coming so I don't expect to see it accelerating until the week after Easter." That is a while ago, and you are talking about 80 prisoners having been released out of a possible 4,000. Are we really going to see that climbing to 1,000 or 3,000 within the next two or three weeks? Can you address the issue about why a scheme that had been planned for a long time— increasing the tagging period, which would have benefited about another 500—is not being taken today?

Lucy Frazer: The approach on our early release is a very careful system. What we want to ensure is that we continue to protect the public. You will remember that we had some issues with it early on, and we paused the scheme to make sure that our processes were really rigorous. They are really rigorous. Each person is individually assessed at prison level. They are looked at centrally. We need to make sure that they do not have, for example, domestic violence risks or safeguarding risks, and that they have a place to go. That all takes time.

We are confident that the numbers will increase as the scheme progresses, but it is only one part of our strategy. The 4,000 was always the number of people who would be eligible for the scheme, not necessarily the number who were released. Of those eligible, we absolutely have to risk-assess the prisoners who come through.

As I mentioned, HDC is already in operation. It is an effective scheme that works well and is part of the toolkit we have. We are committed to the rehabilitation that it offers, but at the moment we are concentrating on dealing with covid in our prisons. The capacity issue has significantly changed since that instrument was laid.

Q146 **Andy Slaughter:** I have one final question on a slightly different topic,

although it is related. We have seen a big growth in the number of older prisoners over the last few years; a lot of it is to do with sex offences, though not exclusively. If you are trying to get the population under control. are you anticipating, in that area of sex offences or other areas, that the number of particularly very old prisoners is going to increase, with all the demands that has, particularly if we are going to get extra police officers, with perhaps more opportunity to prosecute and therefore more people going to prison? What is your strategy for dealing with that?

Lucy Frazer: What we are anticipating is that the population as a whole will increase, and it is likely that the elderly population will increase comparatively with the population as a whole, but it will not increase out of step with the population as a whole.

In relation to the additional police officers, we look at that on a very regular basis. Our analysts spend quite a lot of time working out the impact of that on the estate. How it affects the estate will depend on the sorts of charges the police bring forward and the sorts of crimes they concentrate on. We analyse different scenarios to look at how that affects our projections.

Obviously, if they were long-term, serious offences, including sexual offences, it would have an impact on the older population—probably not immediately, but in the longer term. We look at all those different scenarios when we are looking at capacity, and long-term capacity, in the prison estate.

Dr Farrar: I have a couple of points in relation to our strategy. The Minister mentioned that Public Health England advice has changed. Public Health England reviewed us in March and was predicting that we would have possibly about 2,300 deaths. That is why we took such swift and decisive action to close the prison estate from the movement that it had before, plus the isolation measures that we put in place. That has now reduced the risk over the first curve of the virus to only 100 deaths, which means that our strategy can now be quite different. We do not have the same need as we had before in terms of the prison estate.

We have managed to move 4,000 people out of double cells since February, since this started. We have a far larger number of people in single cells. In the over-50 population, just under 80% are now in single cells. We have a number of people in that population who could go into single cells but who choose to stay in double cells.

Chair: I want to move specifically to points on older people. James Daly has to leave us at some point, and he is keen to follow up. The Minister probably heard his questions to the previous panel.

Q147 **James Daly:** Older prisoners are a cohort with distinct needs that are perhaps met inconsistently across the prison estate. Is there a strategy in place to ensure a more consistent and effective approach towards managing older inmates?

Lucy Frazer: As you know, there is the operational delivery model that sets out how local prisons can operate. You have already heard about the significant work going on across the estate at local level.

Q148 **James Daly:** If there is a strategy for female offenders, who are clearly a much smaller group within the prison population, on what basis is there not a separate strategy for older prisons?

Lucy Frazer: You mean, why do we not have a national strategy for elderly prisoners?

James Daly: Yes.

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

Q149 **James Daly:** We have talked about the model for operational delivery for older prisoners. It states that it was designed to support and inform the prison estate transformation programme. How well can it do that when there is no obligation for governors to follow it?

Lucy Frazer: I speak to governors quite often, and I think there is remarkable work going on at local level where the operational delivery model is working well in practice. You will have heard that from your previous panel. Although it is not mandated, I think it works well. It is good to set these things out at national level. I do not know whether Jo wants to come in this.

Q150 **Chair:** Do you want to say anything, Dr Farrar?

Dr Farrar: Just to add that we have a lot of guidance for governors on a number of different subjects. It is not mandatory, but governors follow it because it helps with the smoother running of their prisons and helps us to give a consistent model of delivery across the estate. The model of operational delivery is supported by governors and in use across the estate. It is wide ranging and helps them to deal with the needs of older prisoners, which, as you say, have grown quite considerably since 2009.

Q151 **Chair:** Mr Clarke, the chief inspector of prisons, says it is almost a strategy in everything but name. Maybe we should just call it that. Any observations, Minister?

Lucy Frazer: He says many sensible things. I am very pleased that he is continuing his tenure in the short term.

Q152 **Kenny MacAskill:** What consideration is given to prisoners' accessibility and mobility needs when they are allocated to a prison?

Lucy Frazer: The most important thing when a prisoner is allocated to a prison is, of course, their risk. That is the first assessment that is made to

determine where they will go. Of course, following on from that, there is an assessment made of their health needs and where their family are living; it is about location and other needs that they may have. It is an important factor.

Q153 **Kenny MacAskill:** With regard to the 10,000 new prison places, will they meet the age profile and accessibility needs of the future prison population, which we expect to expand?

Lucy Frazer: We have actively considered the needs of older people, vulnerable people and those with reduced mobility in our design plans for our new prisons. The prison that we are building in Wellingborough will have seven house blocks. Each of those house blocks will have 12 low mobility units. Overall, 8% of the units will be designed to cater for residents who have physical, mobility or enhanced medical needs. That is more than the last prison we built, at Berwyn. It has seven low mobility cells, so we have significantly increased the type of accommodation in our new builds.

We have not looked just at that. We have also looked at the provision of lifts and at finishes to aid way-finding and orientation for those who have cognitive or visual impairments. We continue to look at that, and we will continue to enhance what we do going forward as we build our other new prisons.

Q154 **Kenny MacAskill:** You touched earlier on the release on temporary licence on compassionate grounds scheme. Have you given any thought to perhaps having a more generous or liberal interpretation of that—for example, for remand prisoners, category A prisoners or those who would only be considered on a restricted licence?

Lucy Frazer: When we release people, we have to consider the protection of the public, which is why category A prisoners would not be included in those releases. In relation to remand, that is an order of the court. It is not in our gift to release people who are subject to an order of the court to be held in custody.

Q155 **Kenny MacAskill:** What is the status of plans to close prisons that are known to be in a poor state of repair? How does that interact with the current drive, understandably, for single cell capacity?

Lucy Frazer: We are very conscious that the prison estate has within it both modern facilities and Victorian premises, which, if we were building today, we would not build as they were designed and constructed. We have done a number of audits in relation to our prison estate. At the moment, we are using the capacity across the estate, which includes those prisons, but we are spending £156 million in maintenance funding this year so that we can improve the maintenance of those buildings.

Dr Farrar: You may have heard from the last panel that in recent years we have made a number of adaptions to our prisons. Obviously, it is more difficult with older prisons, but we have introduced a number of disabled

cells across the estate. We are prioritising work on fire improvements to make areas safer. We have made improvements to palliative care, and we have a number of specific palliative care cells. As the Minister said, we are very excited about our new prison builds because all those facilities will be built into them.

Q156 **Kenny MacAskill:** Minister, I want to ask about alternative custodial arrangements that might be considered, such as secure care homes. I have seen care homes myself that were geared towards dementia and, indeed, Korsakoff syndrome, which afflicts people who are considerably younger and fitter. Might consideration be given to purpose-built type accommodation, as opposed to amending accommodation that was built for entirely different criteria of prisoner?

Lucy Frazer: As I said, when we build our new builds, we are specifically thinking about the older, more vulnerable population and those who have medical needs. It may be suitable for them to be dealt with on a particular wing or at a particular site. Those are things that we will continue to take into operation in our new builds going forward.

Q157 **Maria Eagle:** I would like to come back on some of the points about new prison places. In 2016, the prison estate transformation programme announced that there were going to be 10,000 new prison places built during that Parliament, which coincidentally would have finished very recently had it continued for its full length.

In fact, according to the National Audit Office, 206 were actually delivered. There was a target of 10,000, which is a great intention, but 206 were delivered. How are we supposed to believe, Minister, that you are going to do better than your predecessors in delivering these new prison places?

Lucy Frazer: That building programme is continuing, in the sense that Wellingborough and Glen Parva fall within that programme. That will give us an additional 3,000 places. The 10,000 is in addition to those 3,000. I assure you that it is a very significant commitment. We are still committed to it.

The Ministry of Justice, during the covid crisis, has looked at what work we need to continue as significant, important work to the Department. Our building programme is our top priority, and we have continued to do site visits and investigate additional accommodation where we have existing sites. We are building on those. We are already making plans in relation to those, doing site visits, thinking about planning applications and engaging more broadly. We are absolutely committed to the additional 10,000 places.

Q158 **Maria Eagle:** I very much welcome the commitment, but it is the delivery that matters when it comes down to it, if you are going to make a difference to the prison estate.

In addition to the new prison places, of which 206 have so far been delivered, there were significant plans to sell old prisons and use the money

raised to reconfigure and improve the estate. There is a £900 million backlog in maintenance in the estate, partly as a consequence of the large cuts that the criminal justice system generally, but the prison estate in particular, has had to take over the last 10 years as a consequence of austerity. Only one of those has been sold, although 20 were identified. What is going to happen with those plans? Have they been projected forward as well? Will they go ahead, and will they ensure that capacity within the prison system is reconfigured to make some of the existing estate more disability friendly and more older prisoner friendly?

Lucy Frazer: We have an overriding commitment to protect the public, and in order to do that we have to deliver on our manifesto commitments in terms of our sentencing proposals and ensure that when people are sentenced to prison, they go to prison and serve their term. In order to do that at the moment, we need our existing prison capacity. On top of that we are building the 10,000 additional places, which will increase our capacity, but at that stage we still cannot do away with our older buildings. If we get to a stage at some point where we can build more, or do new for old, that is something that we as a Department are interested in doing.

In relation to the funding, we recognise that there is a maintenance backlog. As I said earlier, we have put £156 million in and currently have an ongoing maintenance programme in place. Of course, you would anticipate that, in the next spending round, we will be looking at the bids we will be making in relation to maintenance and the backlog.

Q159 **Maria Eagle:** There is a £900 million backlog, so £156 million is welcome but is obviously not going to deal with that maintenance backlog. If the reconfiguring of the estate using money from selling old and unsuitable accommodation is not going ahead, it does not seem that there is much capacity for transforming the existing estate, as opposed to making sure that some of the new estate that you are building has more accessible accommodation, does it, Minister?

Lucy Frazer: To clarify, if there is a property that we have said we are going to sell, we are going to sell that property. I reiterate that we have £2.5 billion committed to our building programme. The Ministry of Justice and the Treasury are investing significantly in our prison estate—£2.5 billion on the estate and £100 million on security. As I mentioned, we are conscious of the backlog and will be looking at that in any upcoming spending review.

Q160 **Paula Barker:** As part of the inquiry, we have had some information saying that those who are very frail or have disabilities or severe dementia should be held in a different type of accommodation. The BMA suggested that secure hospitals or similar institutions would be more appropriate for the management of those conditions. Is further consideration going to be given to developing alternative custodial arrangements? It was touched on briefly in an earlier point, but is there any further information that you could give us, Minister?

Lucy Frazer: As I mentioned, our strategy is to ensure that in our new builds we have appropriate accommodation for those who suffer from dementia, as you were talking about in the previous panel, and those who need more mobility. There is great work going on, particularly in relation to dementia, across a whole range of prisons.

We are absolutely committed to ensuring that we have appropriate accommodation for the needs of the prisoners, but we also have to recognise that the people in our prisons are serving a sentence for something they have done. We have an obligation to ensure that that sentence is served and that the public are protected.

Q161 **Paula Barker:** I appreciate that, but could you explain what steps are actually being taken to ensure that the Prison Service can cope with the extra healthcare and social care requirements that come with an ageing population? I appreciate that they are obviously there to serve a sentence, but there is also a duty of care while they are in the Prison Service.

Lucy Frazer: Yes. We have very good relations with healthcare provision in our prisons. You will be aware that there is a national partnership agreement for prison healthcare that was entered into by MOJ, HMPPS, PHE, DHSC and the NHS. The provision of healthcare is primarily the responsibility of the Health Department, but of course we work very closely with the Health Department in ensuring the delivery of healthcare in our prisons.

Kate Davies: One thing that it is important to emphasise is what the partnership agreement and the assessment every year means for the different healthcare needs within all our prisons. It is absolutely crucial to working with the older patients/older person population; it is also to do with gender and ethnicity, and different healthcare conditions. As part of the long-term plan, NHS England has considered, with all our individual regional health and justice commissioners and all our partners, through prison governors and Her Majesty's Prison and Probation Service, how we increase healthcare provision and social care partnership work for the older prisoner group.

One of the things we have been doing is increasing the model around enhanced primary care screening and support for older persons in prison, not only on entry but on a regular basis as part of a complex care register. We have increased end of life care and capacity. As the Minister said, many of those patients are older men who are very unlikely to leave the establishment. It is absolutely important that we invest in elements like palliative care and end of life, particularly around dementia, mental health and long-term conditions.

There has been an increase in the number of patients with long-term conditions. We have relationships with our acute trust sector and there is an improvement in tele-medics; for example, in the past two weeks, also as part of the covid-19 response, we have commissioned over 2,000 new licences for tele-medics. One of the patient groups that will benefit greatly

from that are older patients. Lastly on that point, our dying well charter has been incredibly successful with many of our governors and patients in supporting that care.

I do not think we should underestimate the simple things that the healthcare and social care partnership within prisons is delivering for older patients, particularly around buddying and peer support schemes. Those have been absolutely essential not only to supporting what has been a growing older population in the last few years but in the way that the environments have been adjusted to support patient and prisoner interaction. Peer support has become crucial to the care of some of the very long-term, long sentence prisoners, as well as the younger men and women who are part of that partnership.

Dr Farrar: Kate has talked quite a bit about health, but we also have a strong partnership with social care. We meet regularly at national level with the Association of Directors of Adult Social Services and we talk to the Local Government Association. At local level, we have local delivery boards, chaired by our governors, which bring social care and health together to talk about the needs of their particular prison. We also work very closely with social care on adaptions for individual prisoners. We find them to be responsive to our needs.

Q162 **Richard Burgon:** The Minister outlined some of the work being done across the estate in relation to prisoners in the older age range with dementia, but I want specifically to raise a question on actual dementia training for staff.

In the first panel today, one of the witnesses, who specifically works with older prisoners, said that they thought dementia training "could be better." The Prison Officers Association is clear that it does not think there is a proper level of training and resources for dementia training at the moment. We all want prison officers to be able to recognise and deal with the rising levels of dementia and other diseases. What plans does the Minister have to expand that properly and ensure that prison officers are properly trained and resourced for that crucial thing? It is going to become more and more crucial as the expansion of the ageing prison population continues.

Lucy Frazer: It is a really important point. We have just finished a review of our prison officer training, and it is an important point to look at within that. I know you have heard from various panels that at local level there is good work being carried out. For instance, there is a programme for healthcare teams aimed at increasing the diagnosis rate, by delivering workshops and developing local training for prison officers, in Wormwood Scrubs, HMP Lincoln and HMP Isle of Wight. There is good work going on at local level in dementia training.

In addition to the points I made, it is not just about training; it is also about the configuration of the estate. Nationally, we have done some work that Kate might want to talk about in relation to memory loss.

Kate Davies: I would not underestimate the fact that no prison can run without a good health and social care programme. The governor of Wymott mentioned earlier that there is much planning and discussion about what those services look like, prison by prison. There are elements like memory clinics and speech therapy, and some of the work that has been done, particularly with dementia nurses and the additional capacity of specialists—a mixed economy of healthcare staff coming in because of the older population with dementia—has been absolutely crucial. One of the biggest investments, which I know, Chair, you have scrutinised me on before, is the increase in mental health capacity within prisons. We have worked very closely with our colleagues in NHS England around dementia and equivalence care.

Q163 **Rob Butler:** I would like to move to the next stage chronologically, which is resettlement, and particularly what provision there is for older prisoners when they leave custody. There are two specific aspects: first, the continuation of health and social care that you have just been talking about; and, secondly, accommodation. It is not rare that somebody leaving custody needs to go into approved premises, and there are some questions about the accessibility of many of those premises. Could our panellists address both sides, accommodation and health and social care after release?

Lucy Frazer: On healthcare, we have the £20 million RECONNECT service, where we work very closely to ensure that healthcare continues from prison into the community. It is important that people do not have to start all over again with their healthcare. Two of the programmes in that specifically focus on older people.

In relation to approved premises, some now have accessible bed spaces; 52 out of 100 have at least one accessible space, but we recognise that we need more. We are working to create more in our expansion project.

Kate Davies: I want to come back to the accommodation question and a point made earlier. In many of the new builds, but also in some of the reconfiguration of prisons that is going on as part of reception, training and resettlement prisons, healthcare and public health have been involved with the design and support of that accommodation. That is both as part of the new builds and the adaptation of the current estate, and is a really important and welcome development.

On the point that the Minister made around the RECONNECT scheme, which is a long-term plan priority for NHS England and Improvement, it is new investment and new funding to make quite sure that the most vulnerable patients of all ages who are leaving our prisons, but particularly older prisoners and women, are part of the roll-out over the next five years. That is a very exciting and important prison leaver programme.

Q164 **Rob Butler:** On a similar kind of theme, how easy or otherwise do you find it to liaise with local authorities, for example, to find accommodation if we are not talking about approved premises?

Lucy Frazer: Finding accommodation is a challenge overall, not just for the elderly population. Unfortunately, many of our prisoners do not go into settled accommodation.

We have an accommodation pilot at the moment, working with MHCLG. It is a wrap-around service. It is a programme where we not only find accommodation but provide a person to support the prisoner going into the accommodation. What we often find is that, even if they go into accommodation, that falls away at some point; then they go on and reoffend, and do not manage to find further accommodation. We have a pilot ongoing at the moment where they have a mentor or a person guiding them for two years following their release, to try to get them on track.

That pilot has been continuing, notwithstanding the Covid crisis, and albeit with a few challenges, because it is one of our priorities. We know that people reoffend if they do not have accommodation, a job or family ties.

Dr Farrar: If someone has social care needs, we work closely with social care because they have a responsibility to make sure that there is suitable provision for people. It is not always easy, because there is a need for more accommodation, as the Minister said, but we are working really hard with MHCLG to make sure that there is adequate provision.

I want to mention our offender management and how we are now allocating key workers specifically to older people so that they can work with them on their needs throughout their prison sentence and then help them to make a good transition to the community. We have several pathfinder projects for older people to look at the transition from prison to the community. Our Through the Gate service, which we are enhancing all the time, helps people to find the right provision once they leave prison and move into the community.

Q165 **Rob Butler:** Does that extend to the probation service? Are you looking now at having people in the probation service develop specialist expertise in dealing with much older people as they leave prison?

Dr Farrar: With the Through the Gate process, we hope to have services that are much more tailored to individual needs. It is not specifically to older people's needs but to individual needs. We have probation officers who are very used to dealing with that. It is certainly a point that we can take away when we design the new model, because we have some very good opportunities to make changes to the probation system as we make the transition to a new way of working.

Kate Davies: The work with the National Probation Service has been really important in the last few months, and in recent years, in the development of the RECONNECT service. It is absolutely crucial as part of moving forward. That development and the integration of the whole pathway in prison and on release is something that we welcome with the Prison and Probation Service. It is one of the key improvements in the last six months and a key development that we welcome for the future.

Q166 **Dr Mullan:** We have talked a little bit about health and social care. Generally, your response has been to suggest that collaboration in the provision of service is positive. One of the things we picked up from another witness—the CQC—in an earlier hearing was that it felt specifically that where health and social care was brought together under a single provider it produced a benefit. I do not know whether that reflects your overarching experience of services and whether you would be minded as a Government to encourage dual commissioned services, or you would leave that down to individual decision making.

Lucy Frazer: We have a lot of partnership working already. As I mentioned, there is a national partnership agreement that covers quite a number of Departments, including the NHS and HMPPS. Of course, we have MOUs between governors and partners. Social care is not the responsibility of MOJ but of DHSC. Whatever the structure, it is important that we all work together.

Q167 **Dr Mullan:** I want to pick up on the training issue that you mentioned earlier. Speaking as a clinician, I am very conscious that there is an almost never-ending list of things that various bodies want people on the frontline to study and know about. A doctor or a nurse, or anybody like that, could spend their entire career in front of a computer studying something that someone thinks is of benefit.

I want to get some sense from you of the likelihood of a prison staff member coming into contact with someone with dementia. How do you compute what goes into the training, keeping in mind whether it is likely to be used, versus other things that could be used for training?

Lucy Frazer: There are two key aspects. There is what is done initially on your prisoner training. That includes mental health, but that is not the only opportunity to have training in your workplace. We have heard of some of the local initiatives, where you get training from Age UK or the Alzheimer's Society. That is training for healthcare, but it is also for prison officers. It is a good model as you develop your specialism.

We have particular prisons that have a high number of elderly people in them and some which have much lower numbers. We have different cohorts in different prisons. It is fundamental that everyone learns the basics as they go through their prison officer training. It is then important that we layer on top of that as people develop and go into particular areas or particular types of the estate. That training is important for their own satisfaction and career fulfilment, as well of course as helping those in their custody.

Q168 **Dr Mullan:** Minister, you have articulated throughout this hearing, several times and very effectively, the balance that must be struck in terms of the calls for people to be let out sooner on compassionate leave and all those other things versus the victims of crime wanting to see justice done. Within the system, when we are undertaking reviews like that, how can we best ensure that the voice of victims is articulated?

Sometimes I feel that there is a slight lack of balance because most representative organisations that come before us and lobby in this area are not victims' representatives. How do we keep the balance? You have done a good job of that today in terms of articulating that viewpoint, but, separate from the Government doing it, how do we do that effectively?

Lucy Frazer: We liaise regularly with those representing victims. My colleague Alex Chalk, a Minister in my Department, is responsible for victims, and he and I liaise regularly with the Victims' Commissioner and we talk to victims groups. I certainly take the opportunity whenever I am formulating policy or thinking about a new strategy to try to engage with those on the ground. When we take forward policy that affects prisons, it is as important to speak to prisoners as it is to speak to prison officers and governors. We reach out to those who represent victims and we liaise specifically with victims.

Q169 **John Howell:** Minister, there is a high rate of missed or cancelled medical appointments by older prisoners. Does telemedicine fill that gap? Is it an effective way of making sure that you can get round the current restrictions?

Lucy Frazer: There have been a lot of cancellations and missed appointments, which is very unfortunate. I understand that we have improved the flow. We were collecting data on that, which has been suspended because of covid.

There are a number of ways that we can look at it. One of the things that we are doing in some of our prisons is to install kiosks where you can do the admin and your appointments yourself. Not only does that ease the time of the prison officers, but it gives a little bit of responsibility to the prisoners themselves for their appointments. It also makes it easier to change those appointments.

Kate Davies: We did an audit in 2018 on missed appointments and established the reasons why there are missed appointments, because that is absolutely fundamental to improvement. Some of them were down to the regime, some to individuals not attending and some to healthcare staff. The fundamental issue is that we need a flow in the establishment that understands that healthcare and clinical assessments are essential. Once you get somebody on a care pathway, their appointments for substance misuse and mental health need to be regularly attended as part of that. We have seen a great improvement in that over the last year and a half.

On the question of whether telemedicine for older prisoners becomes a solution, yes, it does. Is it the ultimate solution? No, it is not. On the use of tele-medics, it very clearly says that in-person and one-to-one provision, or even group provision, in prisons for our patients is absolutely essential. It is about how we enhance and bring that together for one and another.

Obviously, in the time of covid-19 and for future planning it is essential. All of our NHS services during covid-19 are working 24/7—seven days a week.

Do not think they are not there. They are there in every single prison, but the tele-medics can enhance those appointments, particularly on the outside of the prison with specialists or between prisons, when there are some issues that are being discussed.

Q170 **Paula Barker:** Ms Davies, you touched on this before in respect of end of life care. We know that there is an ageing prison population, which obviously leads to an increased need for palliative and end of life care. We also know that there is no overall strategy for how prisons should manage that, and there is a lack of consistency across prisons. Do you believe that the Prison Service can meet the needs of end of life care? If not, what can we do to ensure that it is applied?

Kate Davies: One of the things that has been very important is the dying well charter. Prior to the dying well charter coming in, which took two years of development with the Royal College of Nursing, the Royal College of GPs, the Macmillan Trust and our partners in the Prison Service, there was a variety of quality of provision. The end of life charter has been adopted through both Public Health England, the departments and the Prison Service. It has improved the understanding of end of life and individual co-ordinated care.

What has been important, and has been emphasised during covid-19, is that for some of our patients the clinical assessment of their critical care and their intensive healthcare needs means that they may need to go to hospital. Although men and women die in our prison settings as part of an end of life package, many go to hospitals in the community because of their specialist needs and their specialist conditions. That includes pain management and medicines. It is really important that the individual assessment is always there.

As Dr Farrar was saying earlier, it is also looking at which prisons, as we go forward, are developing the environment for end of life. I was in a prison in London only a couple of months ago and saw a very dignified piece of nursing from healthcare staff and prison officers around a gentleman who was sadly passing away and had no family connections. We have to be realistic and say that that happens, but we also have to say that our hospitals are crucial for some very specialised conditions.

Q171 **Chair:** By that stage, the people who have to go to hospital, which is sadly inevitable in these cases, are likely to be extremely sick, aren't they?

Kate Davies: Yes, they are very poorly. Quite often, we do not know that they are necessarily dying. Some have had a stroke, chest pains or their cancer has deteriorated. It may be the first time they are diagnosed or screened for cancer, because of their chaotic lifestyle, and in prison healthcare is the first time they are getting continuity of care.

It is important to emphasise that the prison healthcare regime is really good at identifying vulnerable people, often women with complex cases

who may, because of sexual or domestic violence, have not come to the fore. They have just been coping. Hospitals are a very important place.

Q172 **Chair:** Something we find in the system is that many offenders, particularly on the women's side, will themselves have been victims at some point in their life.

Kate Davies: That is a point I wanted to make earlier. I completely understand the balance between victims and offenders, but the majority of our offenders in the prison estate, coming through the courts and through police custody, are also victims themselves.

We know that an incredibly high percentage of women and men have been victims of violence or domestic violence, either as children or as adults but also currently. It has not been mentioned yet, but the alternative to custody schemes that we are working on at the moment with the probation service and our partners is incredibly important. We have seen many women sentenced to community sentence requirements in the last year, and that is something we would like to see increased.

Q173 **Chair:** Minister, on the back of that, when people have to go to hospital, normally you have to have a couple of prison officers detached to escort them there. There are enough stresses and strains on prison staff at the moment, so is there some flexibility, when you have people who are clearly really sick and are not likely to return to prison? They are not likely to be at risk of escape or further offending. Is there a bit of flex to the system so that you do not have to deploy the number of prison officers to the degree that you would with young, fit men who might be more likely to escape under those circumstances? Is there a bit of flexibility to show a bit of nuance?

Lucy Frazer: I imagine that they would be escorted, but we should bear in mind their condition in the way we treat them as they go to get the care that they need.

Q174 **Chair:** The level of escort may not be as great in some cases. Is that recognised?

Lucy Frazer: They are escorted, as you say, because of the risk of absconding.

Q175 **Chair:** But if they are dying they are not going to be absconding, are they?

Lucy Frazer: You would not have thought so.

Q176 **Chair:** Can we perhaps look at the balance of risk carefully on that one?

Lucy Frazer: I do not know if Jo has some thoughts on that.

Chair: Jo, we would be interested in your thoughts.

Dr Farrar: We take that into account, particularly when people are in hospital at the end of their life. They may not need the same level of escort. We have given a number of people compassionate release, so they do not

have any kind of prison escort. We definitely take that into account, particularly at the end of someone's life.

Chair: Thank you very much; that is very helpful. Thank you very much, everyone, for your evidence. Thank you for taking the time to go through quite a number of questions. We are grateful to you, Minister, Dr Farrar and Ms Davies.