

All-Party Parliamentary Group on Penal Affairs

Co-Chairs: *The Rt Hon Dominic Grieve QC, MP; General Lord Ramsbotham GCB, CBE*

Vice Chairs: *Sarah Champion MP; Sir Edward Garnier QC MP; Kate Green MP;
Rt Hon Norman Lamb MP*

Secretary: *Lord Hodgson of Astley Abbotts*

MINUTES

**Minutes of the meeting of the All-Party Penal Affairs Parliamentary Group
held on 8 December 2015 at 5.00 pm in Committee Room 9**

Speakers: **Nigel Newcomen CBE**, Prisons and Probation Ombudsman
Stuart Ware, CEO of the Restore Support Network
James Bullion, Director for Adult Operations at Essex County Council; and ADASS Lead Director for Care and Justice
Ian Anderson, ADASS Associate Care and Justice

Present

Lord Ramsbotham, in the chair
Lord Beith
Lord Bradley
Dominic Grieve QC MP
Baroness Healy of Primrose Hill
Baroness Howe of Idlicote
James Langstaff, Bishop of Rochester
Lord Ponsonby of Shulbrede
Baroness Quin
Lord Woolf

Observers

Gemma Buckland, Justice Select Committee
Olivia Clarke, Women in Prison
Gordon Cropper, Pentonville IMB
Kimmitt Edgar, PRT
E Dellow-Perry, Office of Lady Hermon MP
Christina Dykes, Office of Dominic Grieve
Win Griffiths
Ryan Harman, PRT
Alex Hewson, PRT
Juliet Lyon PRT
Christina Marriot, Revolving Doors Agency
Richard Nicholls, CLINKS
Malcolm Richardson
Judith Richardson
Andrew Rooke, HM Inspectorate of Prisons
John Samuels, CJA
Jenny Talbot, PRT

Attendees: Mark Day PRT (Clerk to APPG on Penal Affairs)
Julia Braggins (Minutes)

Apologies:

Lord Bowness
Lady Hermon MP
Lord Hodgson

Lord Ramsbotham opened the meeting by welcoming everyone to the meeting. He said that he had regarded the care of elderly prisoners as an important topic during his time as Chief Inspector of Prisons. He had recently attended a meeting of the Care Quality Commission, and asked whether this was on their agenda, as he understood that numbers were increasing. He welcomed the four speakers, and invited Nigel Newcomen, Prisons and Probation Ombudsman, to begin.

Nigel Newcomen: 'As Prisons and Probation Ombudsman my twin roles are to investigate complaints from prisoners and to investigate all deaths in prison. I therefore come at the issue of the treatment of older prisoners from a particular and, in some ways, rather mournful perspective.

Yet, an important test of the humanity of a prison system is the way it manages the most vulnerable. There are few groups more vulnerable than the terminally ill. As these are mostly older prisoners, I believe there are important lessons to be learned about the care of older prisoners from my investigations.

And the number of older prisoners is growing rapidly, growth driven by longer sentences and more late-in-life prosecutions for historic sex offences. As a result, there are now more than 12,000 prisoners over 50, more than 4000 over 60 and some much older still – and the projections are all upwards.

Inevitably, with old age comes ill health and, sadly, increased numbers of deaths from natural causes for me to investigate. Last year, I investigated 155 such deaths – 15% up on the year before. While these deaths were not all among older prisoners, most were, with an average age at death of 58.

The challenge is clear: prisons designed for fit, young men are having to adjust to the largely unexpected and unplanned roles of care home and even hospice. Increasingly, prison staff are having to manage not just ageing prisoners, but the end of more prisoners' lives and, even, death itself.

A recent case illustrates the change underway in our prisons. This concerned the death of a 94 year old man, who had been removed from his care home in his 94th year to serve his first prison sentence for historic sex offences. He died a few weeks later after falling out of bed in his cell. I commended the prison for their care of this man, but for me the case also starkly illustrated the challenge of a rapidly ageing prison population.

Similarly, in my investigations I am now making recommendations for improvement of the care of elderly prisoners that have not previously been of such widespread importance. For example: I have called for improved health and social care for infirm prisoners; I have reminded prisons of the obligation to adjust accommodation and regimes to the requirements of the retired and immobile;

I have encouraged better palliative care for those not allowed to die in the community; and I have called for better training and support for staff, and prisoner supporters, who must now routinely deal with end of life issues.

I have also looked at the issue thematically, to identify more general learning. For example, in a recent learning lessons study of end of life care, I reviewed 278 investigations into the deaths of prisoners over 50 suffering from terminal conditions. Commendably, much of what I found was positive. For example, in 92% of cases where the dying prisoner had known care needs, appropriate adjustments had been made. Some prisoners had been moved to specially designated older persons' wings, or to prisons with 24 hour health care, or even to palliative care suites. Others had been able to remain in the familiar surroundings of their wings, because alterations had been made to their cells.

This illustrates the impressive adaptability and innovative skills of prisons and their staff. However, what it doesn't reflect is a national strategic and appropriately funded approach to the needs of older prisoners - because there isn't one. As a result, the study went on to make clear that there is too much variability in provision and too many cases where care falls short of what one would hope for in the community. For example, in another recent case, an 83 year old wheelchair user was unable to use his in cell toilet as specialist equipment wouldn't fit. This meant he had to use the disabled toilet on the wing during the day and a urination bottle at night. As his health deteriorated, he became doubly incontinent. But, despite being in a shared cell, no action was taken to give him the privacy or facilities he required. The arrangement was unacceptably demeaning for both him and his cellmate.

We cannot escape the fact that the prison estate was built over many centuries and designed and resourced with fit, young men in mind. Responding adequately to the needs of older prisoners, particularly at a time of austerity, is a significant challenge to the Prison Service.

Among the challenges are the growing social care needs of an ageing prison population. From April 2015, the Care Act has required local authorities in England to meet the eligible social care and support needs of prisoners in their area. It is a bit early to assess the impact of the Act and, meanwhile, stopgaps continue. Sometimes undue reliance is placed on poorly trained prisoner carers. At other times, much depends on the good will of staff - but this can sometimes be in short supply. For example, in one depressing case, I found that a 63 year old prisoner who died from multiple organ failure had received no systematic support for his health and social care needs. When wing staff eventually referred him to healthcare because of severe pain, nurses found he was incontinent, dirty, dehydrated and malnourished. Nurses even had to cut his fingernails before they could place an oximeter on his finger to test his oxygen levels. He died a few days later. I was sharply critical of the prison for overlooking even basic

standards of care. Such cases should have no place in a humane prison system. I hope that the Care Act will help consign them to history.

One area where the Prison Service, and its NHS and charitable sector partners, have increasingly risen to the challenge is palliative care. Steered by the 2011 NHS guidelines for end of life care in prison, provision has undoubtedly improved. And, in another sign of our changing prisons, there are dedicated palliative care suites in at least 10 prisons. However, the scale of the ageing prison population means that there is more to do. Thus, in nearly a quarter of cases in my end of life study, there was not even a palliative care plan in place to ensure that needs were identified and addressed. So, unacceptable variability in provision remains.

Let me now turn to some very prison-specific complications to good end of life care. While family involvement is essential to good end of life care, this is not easy to achieve in a secure setting. In any case, the prisoner's offending may have led to family breakdown and they may not want to be involved. Yet on occasions, excellent and compassionate work by prison staff has brought fractured families back together, as the prisoner's death drew near.

Commendably, prisons are also adopting a more proportionate and humane approach to security in terminal cases. There have even been examples of high security prisons facilitating overnight stays for family members at the end of a prisoner's life, and if the high security estate can do this, so can others. In short, prison staff need to be supported and empowered to enable dying prisoners in their care to have what Macmillan nurses call "a good death", in what can otherwise be an inhospitable context.

Another area of tension between traditional prison policies and the new geriatric penal reality is in the use of restraints, for example on hospital visits. Unquestionably, protecting the public is the principal role of prisons, but this is not achieved by inappropriately chaining the infirm and dying. Too often I have had to criticise prisons for failing adequately to balance security with humanity when restraining the terminally ill: a failure which is unlawful, as well as inhumane. For example, in a study of 886 investigations into natural cause deaths, we assessed the level of restraints as the prisoner neared death as inappropriate in 51% of cases. Too often, restraints were used routinely and justified on the prisoner's historic risk not their current state of health. As a result, restraints were left on too long, even to the point of death. A terminally ill prisoner should never need to die in restraints, nor should any escorting officer have to go through the trauma of being chained to a prisoner as he or she dies. With a rapidly ageing population, visits to hospitals and hospices will only increase, and with them daily test of the humanity of our prison system.

Let me draw my brief comments to a conclusion. My investigations indicate that many prisons and their NHS partners have adjusted with care and compassion to

the rapidly ageing populations that they must now manage. But, my investigations also illustrate that provision remains variable. This variability is not helped by the lack of a national older prisoner strategy or sufficient investment to meet the burgeoning needs of elderly prisoners. How well these needs are addressed in future will, in my view, continue to be an important test of the humanity of our prison system. Thank you for your attention.'

Lord Ramsbotham thanked **Nigel Newcomen** for his presentation and said that, sadly, he recognised many of these issues. He then introduced **Stuart Ware**, CEO of the Restore Support Network.

Stuart Ware: 'I first went into a prison in 1996 and I was quite appalled at the way in which older prisoners were treated. As a result, I and a number of other prison colleagues set up Restore 50 Plus, as it was then, which was a peer support network for older people with care needs. I was appalled that so many people with care and mental health needs were coming into prison, with very little support, and then being released.

I thought we had made great strides over the past few years. For example the DoH published 'Pathways to Care for Older Offenders' in 2004, which was a very good guide for commissioners and Prison Service personnel to follow. However, with the Transforming Rehabilitation (TR) agenda, and with the Care Act, things are in turmoil. We are a user organisation and we look at it from the bottom up. And what I am finding from the feedback from our service users is that it is early days for the TR services in prisons to adjust for the needs of older prisoners. The focus is often on the younger ones, who may be employable, so the older ones are getting pushed back as far as resettlement goes. The Care Act is a very good act, but its variability from one prison to another is a bit of a postcode lottery. There is no consistency. I agree with Nigel that we desperately need an overall strategy for older people in prison because numbers are going up all the time.

Let me give you some examples. I have been mentoring a lifer on license in the community. He has severe memory loss. We were trying to access services but no-one wanted to pick it up: he was in his late 50s or early 60s. We put pressure on his GP and local services and eventually they arranged for him to have an assessment. Meanwhile he had a stroke, and I discovered that he was in the stroke unit of a local hospital. He had been there for over two months while they tried to find a care home. He has lost speech, has no memory, and he needs to go into supported care. But where is the care home that will take him, because he is high risk regarding his offences and he has high needs? I believe they have now found somewhere, but meanwhile it has been costing £400 a day, bed-blocking, to keep that person in hospital.

I have another example involving a prisoner in another prison. The adult social services care worker was going in, did the assessment, and the care plan. The

prisoner was coming up for release; he had high care needs, Hodgkinson's Disease, and had already been in care before. The receiving local authority was outside the prison area. They communicated with the receiving local authority. However I discovered he was released homeless, with nowhere to go, high care needs but nobody to pick him up, and it took months before we could get the local adult social services involved.

That's where the problem is. I have seen some good practice in prisons, but through the gate there is no linking up. There is no national strategy. There is a lack of consistency. Nigel will be aware of one person in prison who was a lifer. We had a peer carer looking after him because no prison staff would care for his needs and he could not wash or dress himself properly. We know the care worker only made a few visits to him and yet he was assessed as critical. He was due for support when he died in prison, and I know the Ombudsman was carrying out an inquiry. When the peer care worker was released he was told by the prison authorities: 'that man is never going to have another care worker. You want to look at his offences, and that's why we won't support him'.

I have got to say, however, that there are some fantastic officers in the Prison Service, some very dedicated probation officers, and some very good social care workers. But it is patchy: it all depends which prison or area you are going into, and with an increasing prison population I am not too confident that things will improve.

Finally I am pleased to say that Dr Mary Piper is joining our board, because we want to look at the through-care needs of older people being released. We are setting up our own programmes to complement local authorities, prison and probation, to see what we can do to help older people as they are released to remain independent, and not drive up the costs of care, as happens at the moment.'

Lord Ramsbotham thanked **Stuart Ware** and introduced **James Bullion** Director for Adult Operations at Essex County Council; and ADASS Lead Director for Care and Justice. James Bullion explained that he would be doing a double act with his colleague **Ian Anderson**.

James Bullion: 'The Care Act has come as a very welcome piece of legislation for local authorities. From our point of view, it is important to acknowledge that we have a growing number of older people in prisons, but that's in the context of a growing number of older people with a growing level of needs in communities. So to some extent we have knowledge and understanding of that growth and the issues that it brings, but the prison duty that the Care Act introduced for us in the spring is in the context of a very wide change going forwards in local authority and social services departments per se, around the Care Act and around caring. A great deal of preparatory work has been undertaken to get the legislative changes under way. Ian has been trying to train local authorities in this new duty'.

Ian Anderson, ADASS Associate Care and Justice continued: 'We were invited to join a working group with the Department of Health and the Ministry of Justice in the summer of 2012 to clarify our responsibilities to prisoners under the Care Act. I had only stepped inside a prison two years earlier, after 32 years in local government as a social worker and social work manager, to visit a young man I was working with who was held on remand. And that was where most of my colleagues were at the time: that was how divorced social services were from prisons.

We started last year working with NOMS and the DoH to try to come to an understanding for local authorities of what these new responsibilities might be and how they could discharge them. There was a strong emphasis on pragmatic approaches; what was going to work, what was realistic, what did they need to think about in terms of operating in this secure environment, of which they had no previous experience. So we published service instructions at the end of this year around social care, safe-guarding, and supporting prisoners, and we were very pleased to do that.

We also worked with NOMS to devise a pathway which integrated prison processes with social care processes, to try to help people understand what was the best point to intervene to try to identify a prisoner's social care needs, and what we could do, right through to the point when release was being considered. We produced a number of briefing notes for local authorities and prisons, to help shape their thinking about practical ways of dealing with things. For example if a prisoner is provided with equipment by a local authority and is then transferred to another authority what happens to the equipment? We do not want prisoners being released from prison without the equipment to enable them to have dignity with their day to day lives. We worked with Recoop to produce a series of EasyRead leaflets for prisoners themselves so that they could begin to understand what the Care Act might mean for them.

As regards local authorities, their focus was on two things: one was implementing all the rest of the Care Act, and the other was working with the NHS on the Better Care Fund. Prisons were a very small area of activity for them, alongside all the other things they had to do. So we tried to make the leaflets as simple as possible, and to put on each one, depending on the local authority: this is how you make contact with us. We put an announcement in the weekly bulletin that went out to Directors about the knowledge hub, and a social forum in which they could share information and ask questions; we organised national and regional events to bring people together, to start to shape their thinking; and we did stock-taking exercises to monitor where people were.

So we did a lot in the run-up to the Care Act going live. Having said that, we knew that when it went live most authorities had not got all their 'i's dotted and their 't's crossed because of all the other things they had on their plate at the

time. However we are now in a position where every local authority does know what to do when they receive a request for the assessment of a prisoner; they know what they will do if that prisoner does need care and support.'

James Bullion: 'So by and large that got us to a position in the spring where my fellow directors around the country, all of whom had some arrangements, generally speaking used the existing health care provision in the prison as the access route into adult social services. Whilst that is a beginning position, it does not give us the direct voice in the prison to raise issues that we would like. But it is a start. We have arrangements in place for assessments. We have briefed our social workers and particularly our occupational therapists, and have got them visible and on hand, and we have begun the process of assessment.'

In terms of what has happened during the first six to nine months, we have undertaken regular surveys on the Care Act, one of which was specifically looking at the duty in respect of prisons. I had the findings of that very much in mind, listening to the other two speakers. We have found relatively low numbers of assessments inside, and in some areas no referrals and assessments. I think now everyone has done at least something but in some local authorities we have had just a handful of referrals and therefore very few assessments. In other areas it has been much busier and we have seen some good work going on. So it has been a very uneven and inconsistent picture amongst local authorities.

Generally speaking, in those assessments, which are only in the hundreds, not the thousands, where there is a pragmatic and equipment-based response, we are getting to grips with that and providing equipment to support daily living needs. That is very welcome. But where things are slightly more hidden in terms of needs – older people with mental health problems or with learning disabilities - we are incredibly reliant upon the prison and ourselves working together, to identify the people to refer those individuals across. We recognise we are at the beginning of a journey, and we will see the experience that Stuart has outlined, where we have good practice examples and less good practice going on. We have formed a network amongst local authorities to make sure we spread the good practice around and share the tools around assessment and expertise. We are dependent on a wider integration with health and social services in prisons, and we are also dependent on the wider changes the Prison Service needs to make in its ability to cope with prisoners with ever-increasing needs.

So there is a range of challenges going forward. We think that our role, as well as the Care Act within the prison, needs to extend to the health and social care needs for people in the justice system more broadly, so that we can minimise the numbers going into prison and offer maximum alternatives for people who are vulnerable. And at the other end of the journey, on release, our relationships with community rehabilitation and probation need to be deepened. They are currently not as forceful as they should be.'

Ian Anderson added: 'I think that safe-guarding is an issue. As regards issues of dignity, such as Stuart mentioned in his presentation, a number of colleagues are telling us of things they witnessed which, if they were going on in a care home, would be referred to the Care Quality Commission and dealt with very seriously. The work we are doing in the community generally is about bringing together NHS commissioners with local authorities to think about the whole system and how it could work better. We have got to find a way of shifting that sort of approach into the prison setting, sitting down together, with the prison authorities and with prisoners themselves, to ask: how do we work together to combine our resources to provide more effective support?

There are issues about accessing specialist health services still. Perhaps the prison healthcare contract was not comprehensive enough, and when prisoners need specialist help there are difficulties getting that organised from the community because the trust does not have a contract with NHS England to provide it and the CCGs are not prepared to fund it either because they are not responsible for prisoners. So that sort of thing needs to bed down, as do things round continuing healthcare, which is completely new in the prison environment.

As we look forward, NHS England is reviewing in-patient units in prisons, which are not so much healthcare units, in many cases, as social care units, supporting vulnerable prisoners. If they were to withdraw from those, what does the alternative look like? What is the operating model for it? What is the need for specialist units within the prison estate? How many should there be? What is their function? Do we want to create special units for everybody over the age of 55? (No we don't.) Who should be in there? Do we want to set up specialist care for those prisoners, isolated from the rest of the prison community?

In the community outside we would not be recommending those sorts of approaches. We work on the basis of offering people support at home, to enable them to have the best quality of life they can. In prison, home is the wing. So what can we do, working with our colleagues in the Prison Service, to create an environment where more people can be supported, safely and with dignity, to live on the wings, while at the same time recognising that there will always be some people who have much greater needs and therefore do need a dedicated unit? These would have health support, but would also probably have more of a social care operating model, in terms of promoting independence and dignity, rather than being just about custody. There is a great deal of work going forward to realise and share that vision across the agencies involved, to offer a much better experience for the prisoners concerned.'

Lord Ramsbotham thanked all four speakers for their presentations and opened the meeting to questions.

Dominic Grieve QC MP asked about the issue of compassionate release for prisoners close to death. His impression was of a lack of policy in this area,

leading to inconsistency, which added greatly to family distress. Letters from an MP to the Prison Service and the Ministry of Justice enquiring whether and if so when a prisoner might be released into a hospice received ‘flannel answers’.

Nigel Newcomen agreed. One of the things routinely looked at, where there was a foreseeable death, was whether compassionate release might have been possible. Not all prisoners, however, wished to be released to die, if they had no family. There had also been some instances of ‘unexpected longevity’, and given the political dimension, official decision-making was therefore conservative and risk-averse. Additionally, few clinicians would give a precise estimate of likely date of death. However governors might be able to consider release on temporary license, and, at least, consistency of consideration should be applied to the question of compassionate release, and families should be given a clear picture.

Lord Beith added that the absence of strategy in this whole area was one of the things that had struck him most forcibly during his time as Chair of the Justice Committee. There were a number of things you could do, and a number of people experienced in this field dotted around the country, but you could not call them a ‘strategy’.

Nigel Newcomen agreed that the lack of a national strategy was the main reason for the current chaotic situation. There was some very good provision, but without a strategy, it was unfair to expect this to be consistent across the country. MoJ projections for the prison population suggested that by June 2020 there would be 5,500 over 60s in prison – 25% more than now. He could not imagine that social service colleagues would lack a strategy in these circumstances, and hoped that expertise from outside would push the Prison Service and the MoJ to take a more strategic approach.

The Bishop of Rochester agreed. He also thought that the constraints on facilities in some prisons meant that prisoners would have to be moved to more suitable locations, so a de facto strategy could emerge. Where needs were not being met, it was the natural approach for partners such as the chaplaincy to protest, and to hold the system to account

Stuart Ware added that at present older prisoners were scattered across the prison estate, some in quite unsuitable accommodation. Although he was against ghettos, he thought that older prisoners were frequently unable to get the exercise they needed to keep their joints in working order. If this sort of thing were neglected, older prisoners’ care needs would increase dramatically when they returned to the community.

Lord Ramsbotham said that he had suggested to the Justice Secretary that there should be a named individual in the MoJ who was responsible for older prisoners. Was there such a person?

Ian Anderson said that there was not, although there were some people more sympathetic to this way of thinking than others.

Baroness Howe asked why there had been no mention of older women prisoners.

Nigel Newcomen said that fortunately there were relatively few cases of natural cause deaths among women prisoners, and a much smaller number of women in prison, so few came to his attention. As he understood it, the same issues applied however.

Stuart Ware said that his organisation supported a number of older women prisoners. Most were short sentenced, with drink problems, and were homeless. Every one he knew of had been, or was being, abused. There was nowhere else for them to go. Although they were relatively few, their needs were high, often neglected, and they should not be overlooked.

Baroness Howe said that this underlined Lord Ramsbotham's point that a named individual should be responsible for this group.

Lord Woolf said that when a death took place in prison there may be important faith requirements, for example for Muslims and Jews, where a quick burial was needed. Were these taken into account?

Nigel Newcomen responded that whilst in some cases there was good care and sensitivity to such issues, the picture remained inconsistent. This was another reflection of the Prison Service's struggle to come to terms with the numbers dying in custody.

Lord Woolf wondered whether there was any training for prison staff in this area, as there was for example for NHS staff.

Nigel Newcomen responded that, again, it was patchy.

The Bishop of Rochester said he would raise this with the central Chaplaincy team, which included advisors from each of the faiths. In the wider palliative care world the spiritual dimension was already well recognised.

Lord Ponsonby wondered whether the changes in the way probation was managed were having any knock-on effects in this area, when people left prison.

Ian Anderson responded that the Community Rehabilitation Companies (CRCs) were so new that there was as yet little engagement with local authorities. Also, the local authorities without a prison on their patch had not really thought through

the implications of the Care Act as regards prisoners returning to their area. There remained much work to be done.

James Bullion added that this also raised a leadership issue for local authorities about the role the third sector could play, as well as the CRCs. They needed to bring all parties together.

Stuart Ware said that it was still early days for the CRCs. However his organisation had experienced an enormous increase in the numbers of older prisoners being released homeless. His guess was that the CRCs might be focusing on the needs of younger ex-prisoners. He would like to pick up the suggestion of greater cooperation between the voluntary sector and the CRCs, facilitated by the local authorities. At present, access to older prisoners for many voluntary sector organisations was being blocked, apparently by CRC contracts.

Lord Ramsbotham then opened the floor to non-parliamentarians

Christina Dykes spoke as a trustee of the Revolving Doors Agency. She was sceptical as to whether enough was being done by local authorities to accommodate people with learning difficulties. Places in specialist facilities were very expensive. Who would pay?

James Bullion agreed that this was probably not being well enough done by many local authorities. The financial constraints on local authorities were well known, but the ambition remained to take a holistic view of vulnerable people, wherever they were.

Jenny Talbot from the Prison Reform Trust said that support for people with learning disabilities did not necessarily have to be in dedicated units, but that charities such as Keyring had expertise in supporting people to live independently. This was better for the individual, and much more cost-effective.

Lord Ramsbotham said that, unfortunately, he would have to bring the meeting to a close. He would suggest to his co-chair that they should write to the Secretary of State, telling him the points made and saying that they hoped to see some movement on this issue. The numbers were increasing, and the lack of a strategy was becoming a more pressing problem. He also said that the next meeting of the group would be held in February 23rd 2016. The speaker would be Dame Sally Coates, Chair of the Prison Education Review. It would also include the presentation of the Robin Corbett prizes by Lady Corbett, in memory of Lord Corbett who had chaired this group for so long. Finally he thanked the evening's speakers most warmly, once again, for their presentations.

Julia Braggins 27.12.15
