Report of an Independent Investigation into the Case of AA

Commissioned by the Secretary of State for Justice in accordance with Article 2 of the European Convention on Human Rights

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Executive Summary, List of Findings and Recommendations

At 19.00 hours on Sunday May 2nd 2004 21 year old Ana Attia was found hanging from a ligature on the door in the D3 East Spur showers at Holloway prison. She was lowered to the floor and Cardio-Pulmonary Resuscitation (CPR) was administered before she was taken to hospital. Ana has never regained consciousness and remains in a presumed persistent vegetative state due to brain injury sustained during cardio-respiratory arrest following the hanging. Ana is currently at the Royal Hospital for Neuro-Disability in Putney.

Ana Attia, who had taken the name Shanie Lequan, had been in Holloway Prison since 25th June 2003 when she was remanded in custody facing trial for serious offences. It was her first time in prison. She had been diagnosed as suffering from paranoid schizophrenia. Ana was allocated to the Young Offenders Unit, where she spent almost all her time at Holloway.

She was convicted of the offences in September 2003 and given her psychiatric history she was interviewed by a psychiatrist who recommended assessment by a Regional Medium Secure Unit. A subsequent interview on February 4th 2004 led to the decision being made not to transfer Ana to a psychiatric unit. She remained at Holloway after she was given a three year sentence in February 2004.

Ana was a popular prisoner with the staff and other prisoners but there was little systematic assessment of her needs, and very limited plans made for addressing them.

She was subject to two periods of monitoring under the F2052SH system which was designed to help prevent suicide and self-harm. The first was in July 2003 when she was considered to be low in mood and the second in April 2004 when she was discovered with a ligature round her neck. This monitoring came to an end on April 29th 2004, three days before the incident

of life-threatening self-harm.

Despite her history of serious mental illness and consideration of possible transfer to hospital, Ana had little in the way of sustained input from the mental health services at Holloway. Members of the Discipline Staff on the D3 unit were largely unaware of her psychiatric problems, and despite Ana's two periods on F2052SH, they did not consider Ana to be at risk of committing suicide.

Ana had a complex background and did not give reliable accounts of it when dealing with professionals. She had limited support outside prison and her long-standing boyfriend was banned from visiting her after an incident in the visits room in February 2004.

In the period immediately before her life-threatening self-harm, Ana had learned that her relationship with her boyfriend was over. After a visit from one of her close friends confirming this on the afternoon of Sunday May 2nd 2004, she returned to the unit deeply distressed. She spoke to the chaplain, and was allowed to lodge in a communal cell during the teatime lock-in period. She was allowed to make two calls to her boyfriend from the office, which seemed to improve her mood – although it was commented that she was still upset. After this she was allowed to undertake cleaning duties.

There were two staff members on the unit during the evening duty period when all of the prisoners were locked up apart from those on cleaning duties. One of the staff was a regular officer on D3 unit where Ana was located who knew Ana well. The other was a senior officer who did not. The latter was acting as an "Assist Orderly Officer" with prison-wide responsibilities. During the day one of the other women prisoners on D3, who was subject to an F2052SH, was causing problems by tying ligatures and taking up a great deal of staff time requiring observations every fifteen minutes.

After an officer discovered Ana, staff members applied CPR and were quickly joined by nursing staff. Oxygen was applied and a pulse was detected before the paramedics with the ambulance arrived.

The investigation has made twelve key findings and made fourteen recommendations.

List of Findings

The findings are that:

A. We recognise the importance of psychiatric assessments and the diversion wherever possible from prison of remanded and sentenced prisoners suffering from mental health problems which can more appropriately be dealt with in a hospital setting. However we are concerned at the length of time this process took in this case and the outcome.

B. We are critical of the lack of structured assessment in Ana's case and of the missed opportunities to help meet her needs. Furthermore it is not clear how far the situation has improved at Holloway in respect of cases like Ana's.

C. We are critical of the quality, consistency and integration of the medical care provided to Ana in Holloway. In particular, given her psychiatric history and the opportunities to provide a sustained programme of treatment, the failure of the In-Reach team to take an interest in her case until she had been in prison for so long is hard to understand.

D. We think that the quality of care provided to Ana was adversely influenced by the limited information which staff, particularly those on D3 unit, had about her mental health problems and that this raises important questions of principle and practice about the sharing of

medical information.

E. We think more could have been done to assist Ana with her family problems during her ten months at Holloway and that greater consideration should have been given to the impact on her wellbeing of banning her boyfriend from visiting her.

F. In our opinion, explicit consideration should have been given by staff to the question of whether Ana should be moved to a communal cell during the second F2052SH and this consideration should have been recorded.

G. We consider both periods on F2052SH to have been managed reasonably well but think that the serious physical health problems Ana experienced should have been taken into account when closing the second one. The support plan might have looked at ways of involving family or friends as set out in the local policy and should have contained more in the way of after care for the period following closure.

H. We consider the staffing levels to have been too low at Holloway. In particular, on Saturdays and Sunday evenings when many women may have visits which might prove distressing for one reason or another, there is a need for women to be able to talk to staff.

I. We think that a short discussion should have been held after Ana's return from visits on the afternoon of May 2nd 2004, involving all staff to ensure they knew about Ana's distress and to agree a plan for managing it.

J. We think on balance an F2052SH should have been opened on Ana on May 2nd 2004.

K. We do not think that there was anything wrong in itself with the decision to allow Ana to work on the evening of May 2nd 2004. We do

however think that staff should have sought to supervise that work more closely and would have done so had a F2052SH been opened.

L. We find the response to the incident on May 2nd 2004 was prompt from both discipline and medical staff.

List of Recommendations

Our recommendations are as follows.

1. We recommend that assessments for transfer to psychiatric care are made much more quickly than in Ana's case. We endorse the recommendation in Lord Bradley's 2009 report on people with mental health problems or learning disabilities in the criminal justice system that the Department of Health should develop a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting.

2. We recommend that urgent priority is given to developing and implementing a system of assessing the needs of remand prisoners and those with short periods to serve and a fully functioning Personal Officer scheme.

3. We recommend that more effective models of clinical care are developed for prisoners with diagnosed mental illness and that ways are found to ensure that diagnostic assessments undertaken for the courts are swiftly and systematically used to inform decisions about day to day medical care in prison.

4. We recommend that stronger efforts are made to assemble and substantiate basic information about prisoners' next of kin and family situation, particularly where young offenders are concerned.

5. We recommend that policy on the sharing of medical information in the prison setting is clarified and a training programme established to ensure staff understand its implications.

6. We recommend that the banning of visitors should be a last resort and in the case of young offenders the implications of such bans are taken into account before imposing them. Prisoners should be told of bans and avenues of appeal made known to visitors and prisoners when bans are imposed.

7. We recommend that physical as well as mental health is fully assessed during periods subject to suicide and self-harm monitoring and that consideration is always given to the most appropriate location for a prisoner, in particular whether a move to a dormitory is desirable and the outcome of such consideration recorded.

8. We recommend that the adequacy of staffing levels is reviewed particularly in respect of the needs of women at weekends. We also recommend that stronger efforts are made to ensure residential units are not deprived of staff because of bed watches.

9. We further recommend that Holloway agrees a minimum staffing level and takes action when the level in any area and/or at any time is not reached.

10. We recommend that when prisoners believed to be at risk are allowed to work, they should undertake tasks in the company of other prisoners rather than alone and that staff should supervise their work as much as possible.

11. We recommend that training in suicide prevention is undertaken by all staff who come into contact with prisoners and that the training is refreshed on a regular basis with managers having responsibility for ensuring continued understanding and compliance with the areas

covered.

12. We recommend that clearer guidance is produced on what kind of immediate internal inquiry should be undertaken following acts of serious self-harm, what evidence should be collated and retained and what form of action planning should be set in place as a result.

13. We recommend that a dedicated liaison officer be appointed for any Independent Investigation. The person appointed should report directly to the Governor for the duties performed in this role and should be allowed sufficient time away from normal duties to be able to perform to an acceptable standard and to provide the necessary assistance to the investigation. S/he should have the necessary authority to require the assistance of other staff in providing information requested by the investigation.

14. In addition we recommend that the prison should take a proactive role in providing necessary written information so that, in general, the investigation is in the position of reviewing the documentation and deciding which of that supplied is relevant rather than trying to determine what documents may be available that may be relevant and useful.

GLOSSARY

ACCT	Assessment, Care in Custody and Teamwork: Care planning system used to help identify and care for prisoners at risk of suicide or self-harm (replaced F2052SH)
Association	Prisoners recreation period / time out of cell
Bed watch	A hospital admission of at least one night in length, during which the prisoner requires constant observation for security purposes.
CMHT	Community Mental Health Team
CPR	Cardiopulmonary resuscitation
CMR	Medical notes (also known as IMR: Inmate Medical Record)
DIC	Death in custody
F2050	Main Core Record
F2050 A	Prisoner Personal record
F2052SH	Monitoring system in place in 2004 when a prisoner was judged to be at risk of self-harm or suicide
HDC	Home Detention Curfew
HMCIP	Her Majesty's Chief Inspector of Prisons
Hot debrief	The debriefing of staff involved in an incident as soon as practical after the incident has occurred
IEP	Incentives and Earned Privileges Scheme
IMB	Independent Monitoring Board (formerly Board of Visitors)
IMR	Inmate Medical Record
In-Reach team	Department/Medical Staff responsible for healthcare of prisoners suffering from mental health problems
LIDS	Local Inmate Database System (Computer Record)

MHA	Mental Health Act
NLFS	North London Forensic Service
Normal location	Prisoner's location in main wing/accommodation area of prison
OASys	Offender Assessment System
Oscar One	Radio call for Orderly Officer
Orderly Officer	Principal Officer responsible for ensuring the prison regime is running correctly. Responsible for the management of incidents
PCT	Primary Care Trust
PO	Principal Officer
POA	Prison Officers' Association (Union)
PSR	Pre-Sentence Report
Regional Medium Secure Units	Units which accommodate mentally disordered offenders, whose level of risk is too high to maintain them in general psychiatric services, but who do not require to be placed in high security hospitals.
SCOP	Safer Custody and Offender Policy
SIR	Security Information Report
SN	Staff Nurse
SO	Senior Officer
YO	Young Offender

Part One: The Investigation

Chapter One

How we conducted the Investigation

The investigation was led by Rob Allen, Director of the International Centre for Prison Studies at King's College London. He was assisted by Steven Guy-Gibbens, a retired Prison Governor. A review of the health care was undertaken by Dr Ian Cumming. Administrative support was provided by Fiona Whyte and Arlene Barr.

The terms of reference for the investigation were:

- to examine the management of AA by HM Prison Service at Holloway from June 25th 2003 to the date of her life-threatening attempted suicide on May 2nd 2004 and in the light of the policies and procedures applicable to her at the relevant time

- to examine relevant health issues during the period AA spent in custody, including relevant mental health assessments and Ana's clinical care up to the point of her attempted suicide

- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations.

In the initial phase of the Investigation, Steve Guy-Gibbens and I visited the prison on June 23rd 2009. We met with Ana's mother and her solicitor, Anna Mazzola from Hickman and Rose, on July 2nd 2009. We visited Ana herself with her mother and Ms Mazzola on July 31st 2009. We also talked to Ana's brother and her close friend Mr A on August 7th 2009. We analysed an initial bundle of material which was disclosed to us, comprising the internal Prison

Service inquiry undertaken in 2004. Following this, we prepared a draft sequence of events and a tentative list of issues to explore and circulated these to Ms Mazzola and to the Prison Service. At this stage we also requested further documentation and drew up a list of people whom we wished to interview.

We have undertaken a total of 20 interviews. We decided that we should seek to interview all of those people interviewed in the internal Prison Service investigation into the circumstances of the act of serious self-harm in 2004. We were unfortunately unable to interview three of those, including the two prisoners who contributed to the internal inquiry. The internal inquiry had concentrated on the events immediately leading up to the incident of self-harm and the incident itself and did not consider in any detail the overall management of Ana by the Prison Service.

As this wider perspective formed part of our terms of reference, we decided to interview additional personnel who were involved with Ana's care or had particular responsibilities at the time. We succeeded in interviewing all of those whom we wished to with the exception of one person who worked in the Community Mental Health Team at the time of the incident. We also tried without success to speak with Ana's boyfriend at the time of the incident.

During the course of the investigation we identified the need for a range of additional documentation from Holloway Prison or the Prison Service. Unfortunately not all of this has been forthcoming for various reasons and sometimes disclosure has been slow.

The review of health care was undertaken by Dr Ian Cumming. Steve Guy-Gibbens and I met initially with Dr Cumming on 7th July 2009 and again, to discuss his findings, on November 2nd 2009 and March 29th 2010. His findings have been incorporated into this report.

I presented the outline of our initial findings to Ana' mother and Ms Mazzola on December 17th 2009.

Chapter Two

HMP and YOI Holloway

Located in North London, Holloway is a women's local prison that serves the courts throughout the South East of England. At the end of April 2004, Holloway had a population of 460 female prisoners with 293 staff in post.

Originally a mid-19th century prison for men and women, Holloway became an all female prison in the early 20th century. It was subsequently rebuilt in the 1970s and 1980s and designed as a secure hospital. Cells are located in a maze of corridors and spurs, which do not facilitate adequate observation of prisoners on the units.

Holloway is a prison with many diverse functions. Its main role is to hold women on remand or awaiting sentence. It also has a Mother and Baby Unit and the Young Offender Unit, where Ana resided, that holds girls and young women between 18 and 21 years old. At the time of this incident it also held juvenile girls aged between 15 and 18 years old. Many foreign national women awaiting deportation remain at Holloway following the end of their sentence.

The majority of women arriving at Holloway suffer from alcohol and/or drug problems requiring detoxification. Many are mothers with young children and up to 35% of the population at Holloway are foreign nationals. High numbers of the female prisoners suffer from mental health problems and many have poor literacy and numeracy skills. Holloway has a very transient population with only one in four women still at the prison six weeks after their initial reception. In 2003/04, Holloway accepted 6,500 new prisoners.

Prior to Ana's act of life-threatening self-harm, there had been a self-inflicted death on April 17th 2003. There was a further self-inflicted death in Holloway on May 7th 2004, five days after Ana's act of life-threatening self-harm. Before these incidents the last self-inflicted death at the prison was in August 2002.

Since May 2004, there have been four deaths of women at Holloway, but there has not been a self-inflicted death since 2007.

The Chief Inspector of Prisons concluded in her introduction to the inspection report on Holloway in 2008 that the prison is holding women who should not be held there and whose continued imprisonment is detrimental to them, to the prison and to the long-term interest of society at large.

Part Two: The Background and Events in Detail

Chapter Three

Ana's Identity and Age

AA was born as Ana Amal Attia on July 10th 1982. She was brought up by her mother and has one brother. Her father died when she was young. Ana attended Cranford School in the London Borough of Hounslow where records show that she was a popular pupil who represented her form and year on the school council. Her attendance and punctuality were good (88% attendance rate in year 11 when she was 16).

Ana had been a gymnast at high level, representing Great Britain in tumbling competitions around Europe. She was also a keen athlete and planned to pursue a career in sports. There is no record of her having any contact with the police during this period.

After leaving school Ana attended Weybridge College and worked in McDonalds. She is also recorded as having worked as a part-time fitness instructor but it is not clear where.

In 2000 Ana's mother moved to live in Spain. Ana, who was 18, stayed in London and moved in with her boyfriend F also known as G. Ana had met him when she was 15. He lived with his mother in Isleworth. It is not clear whether Ana stayed continuously with F and his mother. She sometimes gave an alternative address very close by and in March 2003 she told a Consultant Psychiatrist in the Hounslow Substance Misuse Team that she was "essentially homeless, staying with various friends in the Brixton area". Two of Ana's personal contacts on the Holloway PIN phone system are recorded as living in Brixton.

Sometime during the period 2000 to 2002 Ana started to use the name

Shanie Lequan. This appears to be an invented name, based in part on the surname of one of her close friends. It was this name that she gave to the police on May 3rd 2002 when she was charged with an offence under the Public Order Act 1986. A month later when she was charged with assault, on the police record, her name was given as Shanie Hanna Lequan. In December 2002 her name is recorded by police as Shanie Hanna***h*** Lequan and in August 2003, when she was charged with perverting the course of justice, her name was given as Shanie Jordan Lequan.

She was known as Shanie Lequan or Shaney Lequan to the National Health Service from at least September 2002 when she was first recorded as having psychiatric problems.

It was as Shanie Lequan that Ana was known to the Crown Prosecution Service (CPS), her own legal representatives, to the courts, to the Probation Service and to the Prison Service.

Ana's brother told us that Ana had said to him while at Holloway "Don't call me Ana over the phone because my name's Shanie here". He did not seem sure why she had changed her name although he suggested that making up a name might enable her to resume her old name and make a fresh start when she came out. As for the choice of name, Ana's brother confirmed that she felt bonded to a close friend, a version of whose surname she took on.

None of the agencies appear to have questioned whether Shanie Lequan was Ana's real name, although there is a reference "? real name" in a handwritten account of the note of the sentencing hearing prepared by Ana's solicitors. But this is the only hint in the official paperwork that Shanie may not have been her real name.

This is perhaps most surprising in respect of the police and the NHS. The Prison Service did not find out Ana's true identity until after the incident of life-threatening self-harm. The Duty Governor over the weekend of May 1st and 2nd 2004 told us that immediately after the incident "we then followed the

procedure again to try and locate next of kin and it was just a blind alley. There was nothing in her file, no indications".

Although the Prison Service is used to dealing with people who use aliases, this situation was unusual. The Duty Governor told us that:

"I can only think of probably one other similar situation, with a male prisoner, in twenty-seven years' experience. Even then I can't get my head around… how it could happen… that somebody could come into custody, with a false name and then just create a… an identity… which is clearly what Shanie did… or Ana did."

There was also some uncertainty about Ana's age. Ana told the Probation Officer who prepared a Pre-Sentence Report in September 2003 that she "had given the police incorrect information with regards to her date of birth which is in fact July 10th 1985 making her only just 18". In a letter to the judge prior to sentencing in February 2004, Ana claimed that she had been seventeen at the time of the offences she committed and the judge appears to have sentenced her on the basis that she was 18.

In Holloway prison, there was initially uncertainty about her age as well. We were told that there was a question on her arrival as to whether she was a juvenile (i.e. under the age of 18). In fact she was 20 years and 1 month when she arrived at Holloway – a fact that is recorded on the personal summary sheet and the health screen documentation completed on her first reception. The F2052A (which forms part of the Prisoner Personal Record for July 2nd 2003) records that "Shanie is to be treated as a YO not juvenile. All documentation has her recorded as 20".

Chapter Four

Family background and Ana's account of it

Ana had a somewhat complicated family background but the picture which she gave to others about it – and which was accepted by all – was substantially more complex and in many respects untrue. For example Ana consistently told professionals that her mother was dead. A consultant psychiatrist reported to her GP in November 2002 that her problems originated after her mother's death "6 months ago".

Ana told the Probation Officer who prepared the Pre-Sentence Report that her mother had contracted lung cancer when Ana was aged 14 and that she had died in 2002 while visiting Spain. She also said that her mother had given birth to a baby in about 1999 and that she, Ana, looked after the baby after her mother's death. She went on to say that her young brother died in May 2003, while being looked after by friends.

The most detailed picture that Ana painted of her life comes from the interview which she had with a psychiatrist who saw her on November 11th 2003. This interview was undertaken in order to prepare a psychiatric report on behalf of her solicitors in relation to her court appearance.

She told the Psychiatrist that her parents had separated when she was only three and that she had no further contact with her father (and was later informed by her mother that he had died). The Pre-Sentence Report prepared in August 2003 states, by contrast, that Ana had informed the Probation Officer that her father had died when she was 6. Ana told the Psychiatrist that she believed that her father suffered from a mental illness and added that he would walk around the house naked and had abused her mother.

She told the Psychiatrist that her mother had died in 2002 from lung cancer. In the years before her death she had had another relationship with a Jamaican

Yardie and they had a son who had died in 2003. He left Ana's mother after the baby was born and moved to the USA. Ana said that she had an older brother, who she believed was an electrician; she believed that he had a psychiatric history and said that he had a split personality.

An account of her mother's death was also contained in the letter that Ana wrote to the judge in her court case with the words, "when these incidents happened my mother who I adored so much died leaving me with a three and a half year old brother to look after."

Ana told the Psychiatrist that she had been born in Madrid but came to the UK when she was three; shortly after her arrival her parents separated and her father returned to Spain. She reported that she had never attended school but could read and write. In the probation report she informed the officer that she had attended Harlington Secondary School where she was a promising athlete, whereas in fact she attended Cranford School. She said that her mother would hide the children when the authorities came to visit. She had been involved in gymnastics from the age of six (though would not tell the Psychiatrist the name of the gymnastics club that she went to) and then became involved in athletics and ran for her borough. In the probation report she said that she had been part of the Heathrow Gymnastics Club and competed at international level.

Ana told the Psychiatrist that she had worked on two occasions, firstly in McDonalds and then as an assistant at an old people's home until the agency which sent her there closed. She said that she had sold crack to support her younger brother.

Ana reported to the Psychiatrist that when she was 15, her mother began to "act funny" and did not pay the bills. She said that her mother was unwell but found it difficult to live at home and often left home for a month at a time. She reported that before her mother died, her mother went to Spain and left Ana alone with her older brother and half-brother. During this period her mother died and she and her brother had to look after their half brother. Later her

brother went to Spain himself on a holiday but then stayed on and she was left to look after her half brother. She reported that he was often unwell and had asthma. After the offence she had taken him to Spain where he became more unwell and was rushed to hospital during one of his fits. He required artificial ventilation and died. In the probation report she stated that he died at the Hammersmith Hospital in London. She returned to the UK to appear in court for the offence.

Ana reported to the Psychiatrist that she had had two previous relationships and said that though she was heterosexual she was not interested in boys. Ana told him that she had begun to smoke cannabis at 15 and at 16 smoked crack three times a week depending upon finances. Ana had told the Probation Officer that her use of illegal drugs was related to the loss of her mother. Her GP wrote in September 2002 that Ana "has got rather involved in the drug culture since her mum died."

It seems clear that much of the information outlined above is not accurate. Dr Cumming, the psychiatrist who assisted with the Investigation, has concluded that Ana was not a reliable historian; there are many discrepancies between what Ana said about her past and what actually happened. He concluded that the general direction indicates that Ana created a fiction of bereavement and loss in order to develop sympathy. Thus she informed most people that she had lost her mother and her half brother. Dr Cumming notes that that she used this several times in the court process (court reports, probation reports and letter to the judge) presumably to influence sentencing. He does not believe that this was driven by mental illness and more likely that she was simply someone who told untruths and had got into a habit of doing this. He would expect that this had consequences in terms of Ana not being able to talk openly to others about her family to others who might uncover that she had previously lied. Ana's unreliability is illustrated by her list of 'Non-legal controlled telephone numbers' which includes two "brothers" and a cousin. It seems unlikely that these were in fact blood relatives of Ana. She also referred to her close friend Mr A as her brother or step-brother and referred to

her boyfriend G as her brother (see Chapter Six below). She is reported on two occasions as referring to having six brothers.

It is possible that she used the term brothers to refer to close friends rather than blood relatives and indeed is recorded as referring to her mother adopting five brothers.

Reliability extended into other aspects of her background life such as her education and home address – and Dr Cumming believes that she would be similarly unreliable in terms of her substance misuse and involvement in illegal drugs. He judges that there would seem to be a reasonable chance that she did use illegal drugs in prison. One of the security reports refers to her using heroin (see chapter six below). Ana's mother is of the firm view that Ana did not take drugs either in prison or outside. There are no records of Ana having been tested for drugs while in prison.

Members of staff at Holloway were very surprised when they heard that Ana's mother was not dead and that she had created in effect a fictitious identity for herself. One of the Gym staff said:

"I was quite shocked at the time of meeting her mother because Shanie always said that her mother had died of cancer, and that she was left to look after her little brother. So when I met Shanie's mother I was shocked but thought it not appropriate to mention."

One of the Residential Managers at Holloway at the time, who knew Ana well said "It didn't really surprise me that she had got a false age. The name bit, I suppose, you know, it is not uncommon for prisoners to have pseudonyms and other "also known as" side of things. But the family bit, that did surprise me. To actually turn round and tell people your mother is dead when she is not, is quite a, you know, unusual thing, and quite a horrible thing really."

Chapter Five

Ana's Offences and the Court Process

Ana was remanded to Holloway on June 25th 2003 charged with offences relating to the supply of drugs and of wounding with intent committed in September 2002.

Ana's record shows that she had been charged with a number of less serious offences from May 2002 onwards: Disorderly Behaviour on May 3rd 2002, Assault on a Police Officer on June 13th 2002, Handling Stolen Goods and driving offences on October 14th 2002 and Disorderly Behaviour on May 3rd 2003. But the remand to Holloway was Ana's first period in prison.

While in Holloway, Ana was visited by police officers on August 8th 2003 and taken to Isleworth Police Station where she was charged with an offence of Attempting to Pervert the Course of Justice which was alleged to involve witness intimidation on June 25th 2003 at Isleworth Crown Court. This case was finally dropped on February 26th 2004.

Ana was convicted of the offences of Possession with Intent to Supply Drugs after a trial on August 18th 2003 and pleaded guilty to a lesser charge of assault.

A Pre-Sentence Report was prepared by the Probation Service for a hearing on September 10th 2003. This concluded that Ana "would be considered suitable for a Community Rehabilitation Order, possibly with a condition attached that "she keep appointments with our forensic mental health practitioner." Ana's case was further adjourned so that a psychiatric assessment could be undertaken, most likely at the request of Ana's defence solicitors. Two reports were produced and considered by the Judge at

Isleworth Crown Court. The first prepared by a psychiatrist from the North London Forensic Services on November 10th 2003 recommended an adjournment for at least six weeks to consider the need for admission to a Regional Medium Secure Unit. This further assessment was carried out on February 4th 2004 and concluded that Ana's level of distress did not warrant transfer to a psychiatric unit.

Ana was finally sentenced to a total of three years Detention in a Young Offenders Institution on February 20th 2004 – nine months for the assault and two years and three months for the drug offences. On April 5th 2004 Ana was visited by her solicitor who informed her that there were no grounds for appeal. He also informed her that the other charges of Perverting the Course of Justice had been dropped on March 8th 2004 and that another trial for driving offences due for May 10th was not going ahead as the case had been withdrawn.

Of the ten months Ana spent in Holloway almost eight were spent on remand – three months unconvicted and five months convicted but unsentenced.

Ana's earliest date of release was likely to be August 11th 2004, should she have proved suitable for home detention curfew.

As it turned out, the day after her transfer to hospital on May 2nd 2004, she was made subject to a period of compassionate temporary release in order to reflect her situation.

The internal inquiry was told in July 2004 that Holloway was actively seeking a Queen's Pardon, but there is no record of this having been granted. The Inmate Information System records Ana as having been conditionally released from prison on December 23rd 2004.

Chapter Six

Ana's Time and Care at Holloway

a) Location

Ana resided in a variety of locations during her time in Holloway, although almost all her time was spent in the Young Offender Unit. When she arrived at Holloway this was located at D0. The unit moved to level D3 in December 2003. She apparently found the move difficult, initially refusing to move to the newly refurbished unit. She reportedly told the staff member in charge of the unit that she "doesn't deserve things this nice". One of the prison officers at the time told us that at one point Ana had briefly been transferred to C3, a neighbouring adult unit, to show her what she would be missing if she were moved from the Young Offender Unit. The Inmate Information System (IIS) print-out confirms that Ana spent days or parts of days in C3 on five occasions in July and August 2003 and three days or parts of days in A1 – the segregation unit. This is confirmed by the F2052A core record and in a document dated July 9th 2009 which states that there was no space on D0.

Within D3 Ana stayed in different cells although the IIS records are not entirely clear about the location because some of the dates overlap. The Residential Manager, whose responsibilities included D3, remembers that she "wanted to be in a single the majority of the time. She wanted her own space. I don't remember her ever asking to be in a dorm. I do remember her being in a dorm at one point and I believe she asked me about getting her out of the dorm into a single cell". A fellow prisoner and friend of Ana agreed that Shanie "loves her single, she loves being by herself...she doesn't want to be with people."

In fact during Ana's first F2052SH, in July 2003 Ana asked to go into the dorm as soon as one was available. Being on her own in a single cell was also noted as a reason for her not coping when she was found on April 17th 2004 preparing a ligature prior to being made subject to the second period on

F2052SH. It is at least possible that she spent the period from April 22nd until May 1st 2004 in D3 19, a communal cell. Given that she was noted as not coping well in a single cell – in the F2052A (the core prisoner record) but not the F2052SH (the specific at risk monitoring document – see above) – a move to a dormitory may well have been considered. The daily supervision and support record on the F2052SH notes that she went into another prisoner's room for the afternoon of April 17th 2004 and staff are "to encourage her to stay in there for the day." The F2052SH cover sheet gives Ana's location as D3 12 so it seems likely that she stayed in her single.

After she was finally sentenced in February 2004, Ana was noted in the F2052A as being upset at the thought of being transferred to another prison. Normally once sentenced, a woman at Holloway could expect to be moved to another establishment that was better able to provide rehabilitation opportunities. Part of the reason why the decision was made not to transfer Ana was because she had an outstanding court case (although this was dropped shortly afterwards). The F2052A records that "when this matter is dealt with she can remain at Holloway providing her behaviour is good and she is addressing her offending behaviour and meet the targets on her sentence plan. This was agreed with the Area Manager, on December 21st 2003". We were unable to locate any paperwork relating to this decision.

Ana's medical record noted that she was unfit to be transferred to another prison but due to outstanding charges. A fellow prisoner told the internal inquiry that Ana "did not want to be shipped out because I was there and she didn't want to leave me by myself".

As a result, in May 2004 Ana was probably the prisoner who had been on D3 the longest. Another prisoner told the internal inquiry that Ana had been here "more than anyone in this place." Ana reportedly told this prisoner – it is not clear exactly when – how she was tired because she had "been here long enough".

b) Assessment and Planning

There seems to have been little in the way of systematic or coordinated assessment and planning for Ana's time in Holloway, either when she first arrived on remand or later on when she was sentenced. The Deputy Governor of the prison at the time told us that there was very little information about her. "We didn't even know who the next of kin were or if indeed there were a next of kin." In fact there was an initial medical screening, a cell-sharing risk assessment and assessment activities undertaken as a part of Ana's management while subject to periods of F2052SH (see below) although little action appears to have been taken as a result of these assessments.

She was also the subject to two psychiatric assessments but these did not appear to feed into any mechanism for planning and reviewing Ana's progress or well-being.

We could find no evidence of any broader assessments being undertaken once Ana was convicted in September 2003 or when she received a three-year sentence in February 2004.

There does not appear to have been a functioning Personal Officer scheme which would have served to coordinate the information and planning for Ana. The Residential Manager whose responsibilities included D3 told us it was not in operation as it is today.

The entries in the F2052A records show that staff did keep a record, albeit unsystematic, of Ana's behaviour and moods and of significant events, but it is not clear to what use the information was put. There are entries in the wing observation book and in the Continuous Medical Record but in the absence of a Personal officer the information was not pulled together.

c) Involvement in Activities

Ana appears to have involved herself in a variety of activities in Holloway. She appears to have attended education although we have not been able to see comprehensive records of this. She spent a lot of time in the gym. The F2052A notes on September 26th 2003 that she is working really well and puts a lot of effort into everything she does. She is polite to staff and works well with the gym orderlies. Later Ana was herself made a gym orderly for some time although she lost this job at the end of the year, seemingly being more interested in training than working. The PE Instructor reported in the F2052A that she had “been given many chances to improve and has consistently let herself and gym staff down”. She did continue to use the gym “at every opportunity”. During her time in Holloway, Ana undertook a number of courses including the lifeguard course, and received a Community Sports Leader Award.

Ana also worked as a level cleaner, responsible for the laundry and the store. It is not clear when Ana started this role or if it was a permanent or temporary arrangement – it seems possible that she started this after she lost her job as gym orderly.

Ana had some contact with some Catholic nuns who visited the prison and seems to have attended chapel.

d) Contact with Family and Friends

One of the staff told us that Ana’s “family relationships and her support seemed to be other than her aunt in Spain pretty much non existent really”. Given that she was an isolated young woman with limited support, the visits and phone calls she could have were likely to have been very important to Ana.

Ana did have visits during her time in Holloway. The records show that twelve different visitors came to see her during her time there.

Her mother, who lived in Spain, came once with her daughter-in-law and

niece – on November 20th 2003.

Ana appears to have been very reliant on her boyfriend G. Ana referred to him as F rather than G and told staff that he was her brother rather than boyfriend. He visited on a number of occasions but also appears to have let Ana down several times too. On September 21st 2003, the F2052A records one of the officers phoning F on Ana's behalf – F said that he had been late and wasn't allowed in. Ana, when told this, asked the officer to tell him she was sick and tired of his excuses and being late and not to book any more visits. Although F reportedly said "okay", he did continue to visit.

He was banned from visiting after an incident in the visiting hall on February 19th 2004. The security report shows that G (the boyfriend also known as F) was threatening to a prison officer and broke a glass door. He was sent a letter on February 19th 2004 informing him that he "will no longer be permitted to enter the establishment."

Ana's friend Mr A told us that Ana may not have been informed that G was banned with the result that she did not fully understand why he did not visit her after that. This possibility is confirmed by the transcript of the telephone call made by Ana to G on the afternoon of May 1st 2004 – the day before the incident. Ana tells G that she misses him and wants him to come and see her and suggests that he tries to get a forthcoming court case adjourned so that he can visit. Neither Ana nor G makes a reference to the ban. A fortnight earlier the medical record notes that Ana asked a nurse to call G. The nurse did so and G reportedly asked for another Visiting Order to be sent.

In the internal inquiry into the case, the investigating Governor was able to interview two of the prisoners who knew Ana. One of these prisoners told him that on more than one occasion G booked a visit but then did not turn up. She thought that this happened in April 2004 but this seems unlikely because the ban would then have been in force.

There is a note, dated April 27th 2004, in the Daily Supervision and Support

Record during Ana's second F2052SH that the mental health worker "discussed issues relating to her brother's (sic) ban which is now permanent (Incident on visits). Misses his visits /support". The worker agreed to liaise "with Security / Mr ….. re brothers ban visiting."

The Continuous Medical Record for April 27th 2004 records the same discussion, noting as part of the agreed / plan "Memo to security Re: May 2nd ban Lifted?? Can brother visit again."

It is not clear whether this refers to a second ban. There is a record of a visit being refused on April 11th 2004 and again a week later on the 18th. A note "Visits Logged by Establishment for Miss Shaine (sic) Lequan" states for each of these dates "This visit is recorded as being refused however it is not clear if this was by Shaine (sic) or the establishment". There is no Visiting Order (VO) for F later than February 2004 and indeed there is a VO for Mr A which records the visit having taken place on April 11th 2004.

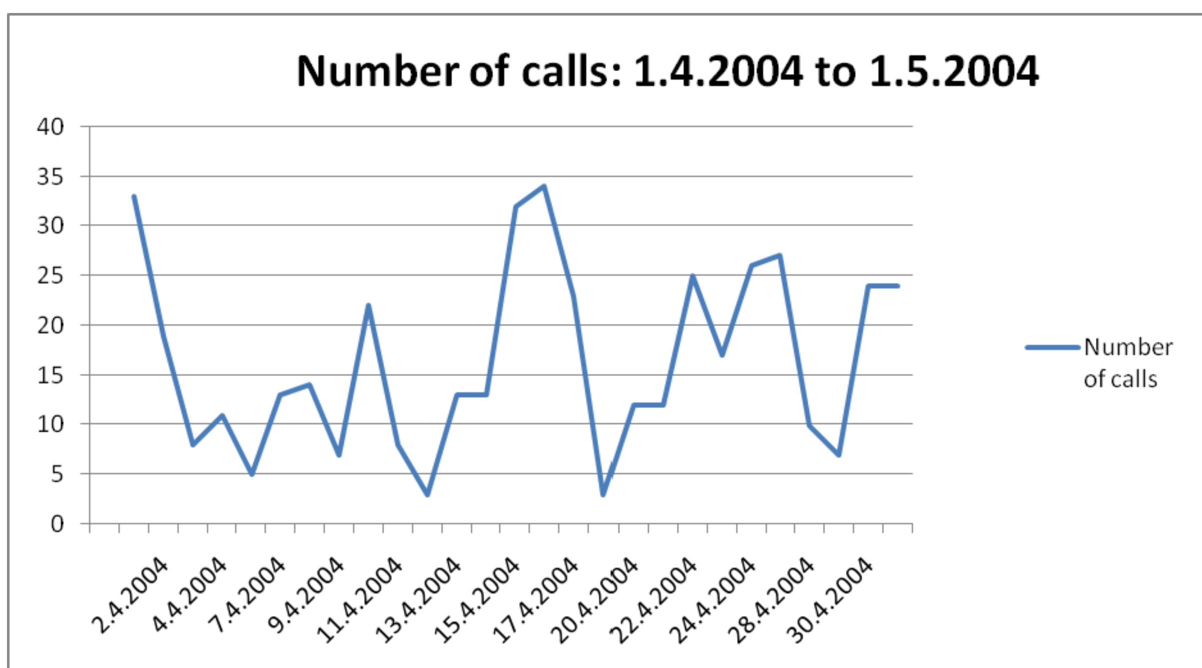
Ana also made a very large number of phone calls to her boyfriend, particularly in the period leading up to the self-harm, indicating that this was an area of great concern to her.

The diagram below derived from the call records report of the PIN Phone system shows that at some points she had made 34 calls to the same number in one day. Ana tried to call G 24 times on May 1st 2004. The records show that the caller hung up in all but four of these calls, on fifteen occasions apparently without being able to get through.

In itself, attempting this number of calls is practically difficult in a prison setting. On January 29th 2004 the F2052A records Ana was "sometimes found using the phone at lock-in time". The HMIP report on Holloway, based on an inspection carried out in October 2004, found that there were two telephones with high acoustic hoods on each residential unit although the Residential Manager whose responsibilities included D3 at the time, told us in his interview that he thought there were three on the YO unit.

A fellow prisoner told the internal inquiry that she would phone G on Ana's behalf – with Ana listening in. Sometimes the fellow prisoner would tell G that Ana had been taken to hospital in order to "frighten him and make him realise." G reportedly told the fellow prisoner that he was missing visits and suggesting he might be seeing another woman "to hurt her because of what she done to him while he was in prison". There is some confirmation of this in the transcript of a call Ana made to G on April 30th 2004 in which G says "I think you have got more than fuckin support off me you know that. I didn't get shit about you when I was in fuckin jail".

The list of telephone numbers which Ana was allowed to call suggests that G may have been in prisons during some of the time Ana was at Holloway but we have not been able to find out if he had been in prison beforehand.



e) Relationships with staff and prisoners

Ana seems to have been a very popular prisoner with both staff and with prisoners. A staff member who in 2003-4 was a Residential Manager and subsequently Head of Residence, said Ana was very likeable – "a lovely

pretty young woman that people couldn't not like". One of the other Governors said she was "bubbly... her own person ...popular." One of the regular D3 officers told us "we all loved, we all liked Shanie on that Unit, we did". The then Residential Manager whose office was close to Ana's cell, told us that "Shanie was such a lovable character, most of the staff had a real, you know, affection for her."

She appears to have been very clean and tidy and stood out in some respects from the other women on the unit. The Wing Diary records her room being among the cleanest in February 2004.

The affection of the staff is reflected by their reactions to the incident of life-threatening self-harm. The current Deputy Governor who was at the time the Residential Manager whose responsibilities included D3 said that "in nearly nineteen years in the Prison Service I have never known staff to go in their own time to visit a prisoner in hospital until Shanie, and I have never known it since". A D3 Officer seems to express a common reaction among staff at all levels "Oh God, I was shocked! I was devastated. 'Cause, like, Shanie! You thought, "Oh my God. Shanie would never do anything like that". In similar vein, the then Head of Residence told us "we would never, ever have thought that Shanie would have harmed herself."

Despite the fact that Ana had been subject to two periods on F2052SH and diagnosed with paranoid schizophrenia, the staff's view was that Ana did not pose a risk of self-harm or was even suffering from a mental illness. The Principal Officer in charge of D3 at the time insists that Ana was not mentally ill – "absolutely not no evidence". The then Deputy Governor did not know Ana was suffering from a mental illness and would not have expected to unless Ana had been badly behaved and come to her attention that way.

Both one of the Governors and the then Residential Manager responsible for D3 feel that Ana did not intend to take her life. The Governor thinks "she intended to go to outside hospital so that the prison would phone the boyfriend who would go and see her. I was strongly of that opinion at the time,

and … having spoken to other prisoners at the time of the incident; they felt exactly the same way. But we'll never know." The Residential Manager told us that he never believed Shanie wanted to kill herself.

A fellow prisoner told the internal inquiry that Ana was not the sort of person who was suicidal. "She loved her body, she loved her figure, she wouldn't hurt herself". The fellow prisoner thought that Ana did what she did in order to get to an outside hospital in part to get out of the prison and in part so that G might visit her there.

f) Ana's behaviour and mood

In fact although she was very well-liked, Ana was not always the easiest of prisoners. Within a week of arriving at Holloway, on July 1st 2003, she was given a warning for going into the wrong class at education (and not leaving when asked by the teacher). This happened again a few weeks later on July 29th 2003. On August 8th 2003, she was moved under restraint, refusing to be examined. The gym had to write up a compact with her landing staff as at times her behaviour would be challenging but according to the gym staff "we did our best in trying to keep her occupied. She was a handful at times but she was a very talented and responded well to staff in the gym. She had a good rapport with the staff and in general conformed to our regime. At one point she was banned from the gym where she generally spent as much time as possible."

More seriously she was reported to have assaulted another prisoner on August 24th 2003, with the Security Information Report noting that a third prisoner informed an officer that this was over drugs. A month later, on September 22nd, Ana was reported to have been smoking heroin. Dr Ian Cumming assesses that there would seem to be a reasonable chance that she did use illegal drugs in prison. Ana received an Incentives and Earned Privileges (IEP) warning on September 20th 2003 for being rude and abusive to staff.

She refused to go back to her room on October 10th 2003 and was involved in another fight on December 3rd 2003. A security report on December 4th 2003 reports tension between Ana and another prisoner and that threats have been made to 'jump' Ana. Another entry relates to the note that they had tried once before.

Ana's behaviour can best be described as up and down during her time at Holloway. In the days after Christmas 2003 the F2052A records note that Ana was "becoming a discipline problem again" and her behaviour is "deteriorating rapidly again". Earlier in that month, Ana was referred to "Anger Management Psychology due to her feeling out of control and not being able to express herself without the anger or violence". Psychology could not offer any help until February 2004 and it is not entirely clear what if any help was in fact given. The Psychiatrist who saw Ana on February 4th 2004 reported that her impulsivity had been addressed by an anger management course with good results, but there is no other record of this.

After this period, Ana's behaviour is reported as improving with her being well-behaved most of the time, receiving praise from staff for example for helping translate Spanish.

The psychiatric assessment undertaken in February 2004 noted that she had been involved in a confrontation with other prisoners and staff which had led to several adjudications.

On February 19th 2004, Ana was given a warning about her behaviour in visits following the incident which put several members of staff at risk and after which her boyfriend was banned from visiting. The related Security Incident Report notes that "this woman has been brought to security's attention on numerous occasions for assault, drugs."

Later that month, on February 29th 2004, another prisoner reported that she had received hate mail from Ana and on March 18th 2004 Ana received pictures of men with guns which alerted the attention of the security

department. On April 11th 2004 there was an incident in which a photograph of Ana's mother was stolen out of her room, scribbled out with biro and thrown out into the garden. The F2052A file reports Ana taking the news of this very well. "Her behaviour was totally unexpected by staff considering Shanie's temper".

A week later, on April 18th 2004, the F2052A file records Ana as being "down lately as prison life has got to her" and reports the opening of the F2052SH monitoring. Two days before the incident of life-threatening self-harm, the file records her as improving dramatically – "She has been wing cleaning and is a lot happier."

The F2052A records contain many entries that confirm the positive picture given by the staff. On March 8th 2004, Ana was "in very high spirits all the time." On March 14th 2004 she had sustained a scratch from breaking up a fight. Some of the negative reports no doubt reflect Ana's bubbly personality such as when she was noted to be "constantly talking out of her hatch with others down her spur."

Chapter Seven

Health Care

a) Previous Psychiatric History

Ana told the Psychiatrist whom she saw in November 2003 that she had previously seen a child psychologist with her brother and attended a clinic in Uxbridge for around six months and told him that she "hated going because they asked questions so much."

She reported that when she was 16 she began to hear voices "when smoking" and became "paranoid" that people were talking about her and "I couldn't watch telly.. I hear them wrong. When they talk I hear things wrong and I don't like it. I hear people talking about me and I get paranoid."

Ana said that she attended the West Middlesex Hospital and saw a Doctor adding that she believed this was on the drug unit. She told the Psychiatrist that this Doctor had told her that many of her experiences were probably due to drugs and offered her treatment if she stopped. She told the Psychiatrist that she had lied to this Doctor about stopping drugs and was prescribed medication for schizophrenia. She told the Psychiatrist that she continued to hear voices which said things to her such as "prick", "laughing" but did not wish to discuss it further. Ana told him that she did not go into the television room in the prison and heard "little laughters" which she ignored. She also reported hearing the voice of her mother in her head. She said that when she went into a room and heard friends laughing, she knew they were laughing at her and being spiteful. When she brought this to their attention she said that they would say that she was hearing things.

She recalled an incident a few days earlier when her bag had been stolen and had heard a voice telling her that another prisoner had stolen it.

The Psychiatrist obtained information from her GP, who had written to the instructing solicitors in Ana's court case. The GP confirmed that her mental health problems began in September 2002 and after the death of her mother in May 2002. She contacted the GP out of hours service on September 22nd 2002 having suicidal thoughts and fear about impending court cases and going to jail.

We also know that Ana was referred to the chemical dependency unit and seen by the Doctor there in November 2002. At that time she reported hearing voices which interfered with her thoughts and also felt that occasionally the television was communicating with her. On that occasion, the Doctor made the diagnosis of a psychotic illness. He treated her with the anti-psychotic drug sulpiride and initially he felt that she made a good response. However Ana failed to make follow-up appointments and "clearly did not take the medication prescribed." The GP offered the opinion that "this illness will be recurrent and possibly worsen without appropriate treatment".

The records show that her referral form to the chemical dependency unit at the West Middlesex Hospital identified Ana as using heroin and cocaine. The substance misuse team offered her an appointment to see the Doctor there on October 31st 2002. The Doctor there wrote a letter to her GP on November 25th 2002 after two appointments with Ana on October 31st and November 14th 2002. She reported hearing abnormal sounds including muttering which she would not discuss. She also reported odd experiences from the television and he identified problems with anger control, increasing irritability and sleep difficulty. The Doctor at the Substance Misuse Team also acknowledged that she had been involved with the community mental health team. Ana had admitted using cocaine and heroin regularly, and at one point daily over the preceding three months. He also noted that she had used cannabis from her early teens but had used less as she grew older. He also noted a history of excessive alcohol consumption. The Doctor at the Substance Misuse Team commented that "I would not be confident that her mental health symptoms can necessarily be explained by her reported drug abuse" and he commenced her on an anti-psychotic.

Ana failed to make subsequent appointments on January 2nd and 30th 2003, but attended again on March 13th 2003. At that time she informed the Doctor at the Substance Misuse Team that she had moved and was effectively homeless. Ana said that she was working part-time at a gym but had to give up college because of poor concentration. He noted that she continued to hear voices. He noted that she was not taking medication and denied illegal drug use. She did not attend appointments on April 3rd and May 1st 2003 and was not given further appointments.

Ana's brother told us that he did not think that Ana had mental health or drug problems.

b) Arrival at Holloway and the first two weeks

On June 25th 2003, when Ana arrived into custody, a first reception health screen was completed. This recorded no recent contact with her GP but Ana admitted smoking cannabis in the past and that she had been diagnosed as having paranoid schizophrenia. She revealed a history of self-harm in the form of self-inflicted cuts to her face in September 2002; she also stated that her brother had attempted suicide. She said that she had been on medication – the name of this is not recorded. She denied feeling suicidal or wanting to hurt herself.

In Ana's Continuous Medical Record dated that day is recorded, "?paranoid schizophrenia" and the word "diagnosed" followed by an entry which it is not possible to decipher. There is an entry which appears to read "to contact GP" and what appears to be a prescription for Diazepam.

On July 7th 2003 it is noted in the Continuous Medical Record that Ana stated that she had been taking an anti-depressant and anti-psychotic medications previously but could not recall the name. The GP surgery was contacted and the receptionist stated that Ana was not registered with them. It was planned that Ana would be reviewed by a doctor two days later.

On July 9th an entry in the medical record notes that the prison was awaiting a reply to their consent form and Ana said that she would contact her solicitors to obtain a copy of her records.

c) The first F2052SH: July 13th - August 13th 2003

On July 13th Ana had an F2052SH opened at 14.30. Ana was noted in the report of the initiating member of staff to be "very low in mood" and revealed both past incidents of self-harm and suicidal thoughts at that time. Ana said that her mother and brother had recently died and she had no other family. She said that she was scared of a long sentence and cried herself to sleep most nights. Ana asked to go into the dormitory as soon as one was available. The F2052SH form records her changing location at least three times during the period of monitoring.

The initial plan included her being seen by Chaplaincy and using the Samaritans phone when necessary. Ana was recommended to continue with the gym and education and to see psychology and receive other staff support. It was recommended that she be observed four times a night.

On July 16th, Ana is reported in her medical record as "being low in mood and affect." She had good eye contact but reported early morning wakening at 5am. Venlafaxine (an anti-depressant) was started at a dose of 75mg a day; she was also put on Acyclovir for a cold sore. It was noted in the medical entry in her F2052SH form that she was due to see the Chaplain and her family were in Spain. No issues around self-harm were noted and it was commented that she had a history of auditory hallucinations but "only in conjunction with cannabis."

Her first 72 hour F2052SH review took place at 12.00 on July 16th 2003. Present were a Senior Officer, an Officer, and Ana who revealed that she was still crying, and had thoughts of self-harm. She said that she would hang herself if it she was to attempt suicide. It was noted that this was her first time

in custody. It was noted that she has her "days – these are when she is finding it particularly difficult to cope with the confines of prison." It was felt that Ana should be encouraged to continue with her employment and the unit and to see Chaplaincy on request. She was recommended to have education in her room and for her supervision level to be held at three times in the day and hourly at night.

On July 25th, Ana had a second F2052SH review with the unit PO and SO. Ana was noted to be still very upset and had problems with depression. Ana reported that during two of her visits earlier in the week, the visitor had not turned up. She reported that she had little support and although not suicidal she was tearful and upset. She was at that time in the dorm and had support from the other prisoners. Staff were asked to observe her mood and to contact Chaplaincy again. The same observation levels as on July 16th 2003 were maintained.

On July 30th Ana said that she was feeling much better and had refused her Venlafaxine and had seen the Chaplain. Her sleep was better and the antidepressant was discontinued.

On August 4th in another F2052SH review, it was noted that Ana was not very cooperative and had had an argument with another prisoner and was upset and agitated. The security file noted that she had become abusive and refused to move and needed to be restrained. She was escorted to the Segregation Unit and was noted to be verbally abusive afterwards. The next day she was found guilty of disobeying a lawful order and awarded 14 days stoppage of earnings and 21 days loss of canteen facilities which upset her. Ana continued to be rude and abusive.

On August 13th 2003 in her final F2052SH review, Ana stated that she had "no intention of hurting herself" and "she said that she does get depressed and this is when she becomes negative." It was commented that her behaviour the preceding week was due to being in a "dorm" with "two foreign nationals who were not speaking English." It was commented that "she stated

that she became paranoid about what they were saying." Ana was noted to be "more positive at the moment" and was enjoying the gym. The F2052SH form was closed.

d) August 13th 2003 to April 17th 2004

The Pre-Sentence Report produced for the court appearance on September 24th 2003 says that "she has experienced what appear to be cannabis induced psychosis, this has involved auditory hallucinations and feelings of paranoia. She has received psychiatric treatment in the past and tells me that she has attempted suicide in recent months".

On November 10th 2003 Ana was seen by the Psychiatrist from the Forensic Services for the psychiatric assessment report. In his entry he notes that Ana did not want the details of her interview noted as she was concerned that prison officers would know of her mental health history and that this would alter the way that she was treated. He commented that she should be started on an antipsychotic. He commented that she did not have suicidal or homicidal thoughts.

On November 29th the same Psychiatrist reviewed Ana again and noted that she was still experiencing auditory hallucinations and detailed these as "whispering" which she ignored. He noted that Ana wanted to start medication and agreed that his court report should go into her notes.

The Psychiatrist started her on Amisulpride at a dose of 600mg and with a plan to double this if no response after review in 6 to 8 weeks. He noted that he had informed her of possible side effects. The report recommended that Ana be further assessed by forensic psychiatric services in her catchment area in order to consider whether she needed to be admitted to a Regional Medium Secure Unit for a period of further assessment.

On February 4th 2004, Ana was seen by a Specialist Registrar from the Tony Hillis Wing at St Bernard's Hospital in response to this referral from the

Forensic Services. This was eleven weeks after the initial report (which had recommended an adjournment of the court case for at least six weeks). At the time of the assessment in February 2004 Ana had been taking Amisulpride for only two weeks – in November 2003 – but it had been discontinued and it is not clear why as she had not had medication for around 6 weeks.

The Psychiatrist from the Tony Willis wing at St Bernard's Hospital noted in his assessment that Ana had been involved in confrontation with other prisoners and staff which had led to several adjudications. She informed him that she heard the voice of her mother calling her on a daily basis and usually when she was alone in her room. She had removed pictures of her mother to make this experience go away. It was also noted that she heard another voice which said "mean things to her." She also admitted a past experience of feeling that the television talked to her and feelings of stress with others. She denied ongoing use of illegal drugs.

The Psychiatrist from St Bernard's restarted the anti-psychotic and recommended that it be continued. He felt that she was symptomatic but her "current level of distress" did not warrant transfer to a psychiatric unit. He noted that "should her condition deteriorate she may warrant reassessment and consideration of transfer". He copied the letter of assessment to the In-Reach Team, i.e. the Community Mental Health Team, in order to "ensure she is followed up appropriately."

On February 5th 2004, Ana complained of insomnia over the preceding weeks and that she was feeling "unduly excited." She was noted to have some worries over her brothers. She denied any concerns about her court case and it was noted that she had bled with the Amisulpride.

It was noted in her medical record on April 3rd 2004 that she had refused to take her Amisulpride for around two months and thus was not re-prescribed. The F2052A recorded that she was behaving well but that if she did not get her own way "she stamps her feet" and "sulks for hours."

e) The second F2052SH: April 17th - April 29th 2004

On April 17th 2004 at 12.30 an F2052SH was opened. Ana had been found in the East Bathroom at 11.30 a.m with a sheet tied to the door. The Staff Observation Book records that she tied a ligature but an entry in the margin says that she did not actually tie the ligature. It notes that “she was very tearful and distressed regarding her long stay in Holloway. Feels as if she’s not been coping very well recently being on her own in single cell, lack of family contact”.

The F2052SH document records that Ana said that she could not cope anymore - and that she missed her mother who died a year and a half before. She was upset that her family are arguing and she cannot help them. Ana said that she “did not want to be here.” A Mental Health assessment undertaken three days later on April 20th 2004, records that “tying the ligature was very much a cry for help, because she did not feel that the staff were taking the pain she was suffering seriously” – this may refer to physical pain (see below).

Ana was allowed to make a phone call to her “brother who has been banned from visits” (in fact her boyfriend G/F) and was allowed to lodge with another prisoner in a double cell.

At 18.00 Ana was seen by a nurse and an entry made in her medical record. Ana was noted to be feeling depressed and she stated that she was not sleeping. Night sedation was prescribed.

On April 18th 2004 Ana was reviewed but declined to restart her medication. She said that she was not eating well and felt overwhelmed with the “unknown” when she would be released in three months.

A later entry was made in the medical record after the F2052SH form had been opened. In this entry it was noted that Ana was feeling low and depressed. It was commented that she had tied a ligature in the bathroom. It

was noted that she was due to be released and had “lots of issues mainly personal” but did not want to discuss them. She stated that her mother had died but she had had no bereavement counselling. She reported six brothers who were supportive. She declined a review by a psychologist and refused her medication (due to interference with her period). She was referred to see the Community Mental Health Team (CMHT), the psychologist and given night sedation. Ana had a visit recorded as refused.

On April 19th 2004, the Staff Observation Book notes that Ana “has every intention of killing herself, has not eaten for four days and is unwilling to accept help.”

On April 19th 2004, it is noted in the medical record that Ana was refusing to eat and drink and had not eaten for four days. She had not passed urine since the previous day. She did not want to talk but said that she missed her mother who had died some years ago. An urgent referral was made to the CMHT and psychologist. Her case was discussed with a Doctor who was based on C1 unit. It was noted that she had a history of schizophrenia and that she said that she did not want to live. A relapse of her illness or a severe depression was considered.

Ana later had a drink after persuasion; she discussed her favourite brother and she was noted to be tearful but her mood brightened. She asked for the interviewer to ring her brother – in fact her boyfriend, who asked her to send him a Visiting Order.

In a lengthy entry in the medical record (though this appears to relate to earlier in the day) it was noted that she had been reluctant to talk and was tearful and angry intermittently. She said that her brother lived in Spain and she did not get on well with him. She said though that she had five other brothers who were all adopted by her mother. She was noted to get on well with a person referred to in the records only by their first name, who was noted to be dyslexic and made frequent requests for money and refused to talk to her when she did not give him any. She then noted that she was

unable to help him from prison. She blamed herself for letting the family down and thought that she was a rebel. It was noted that she had negative perceptions of herself.

Ana had talked of wanting to be with her mother and said that she was still grieving for her mother. She reported being low in mood and was tearful during the assessment. She was noted to be actively suicidal and still wanted to die and not to eat. It was noted that she was very suspicious of staff.

On April 20th 2004 Ana was noted to have haematemesis (blood in vomit) and looked pale. She was seen and examined by a nurse practitioner.

The Mental Health Team saw her in the afternoon and produced a Mental Health Assessment Report. She was noted to be low in mood, but had no expression of suicidal thoughts. She said that she was hearing voices when using cannabis in the past but said that she was not taking any cannabis at that time. Ana talked about her physical complaints including not eating and drinking and the report recommended that a further exploration of the diagnosis of paranoid schizophrenia be undertaken “because I saw no evidence of mental illness in my interview”.

The notes in the CMR say that an urgent assessment should be undertaken by a doctor. The Community Mental Health Team planned to review Ana the next day.

A Doctor saw Ana later that day in view of her not having eaten or drunk for 72 hours. It was noted that Ana had eaten at lunchtime but vomited. In addition to the physical issues, it was noted that Ana was downcast and had poor eye contact. A physical examination was undertaken and a plan was developed to encourage fluids (little and often) and monitor her input and output. Ana was given Paracetamol, bloods were taken and a urine sample was examined for infection. It was also recommended that there was a further medical review the next day by a doctor and “'? CMHT”, [Community Mental Health Team].

On April 21st 2004 at 15.20 hours, Ana did not attend for her blood test that morning and it was noted that she had still not passed urine – though it was noted that she was not dehydrated. She was given a litre of water to drink slowly, and it was noted that she had vomited that evening after drinking.

At 17.30 Ana had still not passed urine and had vomited again with streaks of blood in the vomit. She had abdominal tenderness and she was referred out to the local Accident and Emergency Unit at the Whittington Hospital. It is not clear what treatment Ana received at the hospital.

At 00.30 on April 22nd Ana returned from hospital with analgesia; her night sedation was stopped. She appeared low in mood according to the F2052A and was allowed to use the Samaritans phone on B3 unit for 30 minutes.

In the morning and throughout the day on April 22nd 2004 Ana appeared to be brighter. The next day, April 23rd 2004, Ana appeared to be much better. A brief review by the Mental Health teams reports that Ana “states she feels much better since attending hospital and receiving treatment, mental state appears fine, currently wing cleaning – review again next week”.

The daily supervision and support record during the remainder of the period on the F2052SH describe Ana coming back to her old self – with the exception of one entry on April 28th 2004 at 19.00 which records “Had a long face and I asked her what was the matter – she said “I just want to go home, I have had enough.” I told her that she is going home soon but she still sounded bad”.

The next day, Thursday 29th April 2004 the final review was held with the forms recording “No signs of self-harm – in good spirits: F2052 SH closed.”

The Residential Manager whose responsibilities included D3 told us that on Friday April 30th 2004 Ana “seemed really quite happy, quite jovial”.

Transcripts of phone calls with her boyfriend made on the afternoon of that day and on the following afternoon indicate that Ana was concerned about the state of her relationship and also about something else that she says she will have to do but which it is not possible to comprehend.

Chapter Eight

May 2nd 2004: The date of the life-threatening self-harm

Ana attended chapel in the morning of May 2nd. She asked if she could have a word with the Chaplain after the service, presumably to talk about the fact that the relationship with her long-standing boyfriend, G, had come to an end. The Chaplain could not see her immediately but promised to talk to her later in the day.

Ana received a visit in the afternoon from her friend Mr A. He told us that "She was very down, very depressed, she'd told me that she'd spoke to him [G] the night before, or was it two days before, one of the two and she had found out that he has got another partner, a new girlfriend, so she was really down about it and she kept asking me who is this girl, have I met this girl, what does she look like, you know the kind of questions women ask in situations like this?"

Mr A said that he had never seen her like that before. "She was very down. White."

The staff in the Visits Room recognised how upset she was. According to Mr A "they were caring people…they kept bringing tissues to her, checking that she was ok you know, actually coming physically asking are you ok, you know."

After the hour-long visit, Mr A had to leave. Ana was "still upset. Yeah, cos he was the love of her life you know? The only boyfriend she really had a relationship that had lasted for perhaps eight years."

Mr A says he spoke to the staff about her distress but they were already aware of it and one of the visits officers alerted the wing.

Ana returned to the wing still highly upset. SO S described her as inconsolable and saying, “please doesn’t leave me”. Sometime between 15.30 and 16.30 the Chaplain came to talk to her as he had promised earlier in the day.

The Chaplain told us: “From what I remember she was very distressed, she was talking particularly that her boyfriend had now, who she, from what I remember, was living with has basically told her that he’s found someone else, who is moved in, and so she’s been given the cold shoulder and presumably told that it’s over, he’s found someone else while she’s in prison. She was very distressed about that. She was in tears.” The Chaplain told us that he seemed to remember Ana saying that she’d done something very similar to G when he had been in prison.

The Chaplain said that he would like to think that the conversation helped “even if it was just her feeling able to talk to someone and to share the distress that she obviously felt.” After talking to Ana, probably for about fifteen minutes, he went into the staff room and spoke with the staff. The Chaplain was encouraged that the staff members were very concerned about Ana and they told him that they had made arrangements to put her into a cell with a close friend of hers for mutual support and help. Senior Officer S who was responsible for D3 that day could not recall whose suggestion it was.

Ana lodged with another prisoner, a fellow wing cleaner with whom she was close, in a communal cell during the lock-up period after tea at about 17.00. This prisoner told the internal inquiry that Ana was unusually upset, saying “I can’t do it no more, I want to go home, I can’t do it”.

One of the staff, a regular D3 Officer D did not know that the decision had been made that Ana should lodge with her friend because she told us that it was not until she unlocked the cell 45 minutes later that she found Ana.

We were not able to interview the prisoner with whom Ana lodged, however this prisoner told the internal inquiry that Ana was “proper distressed, crying

all the time crying”. Once in the cell, Ana got into bed with her friend and cuddled her tight. Her friend thought this “weird because she wouldn’t do that”.

Her friend also reported that Ana had asked Officer J if she could be moved to a communal cell for the night and that this request was refused. We asked Officer J about this but she could not remember such a request being made.

At about 18.00, Officer D unlocked Ana and she told us that Ana had obviously been crying. Ana came out and said she wanted to work. Ana was one of three prisoners who worked as a cleaner on the unit and would normally have expected to do so until 8 pm. Officer D saw Ana sitting on the chairs opposite the phones. Ana asked if she could make a call to her boyfriend from the office, presumably having no credit of her own. Officer D said Ana was still upset and frustrated, saying that she needed to speak to her boyfriend to find out why the relationship had ended. Officer D asked SO S who was in the SO’s office, if Ana could make the call and she agreed to this request. In the event Ana made two calls.

SO S was in the office when the call was made and recalls that Ana “was upset and inconsolable on the phone…. and she couldn’t really speak to him. I’ve asked her to try and compose herself, ‘cause it wasn’t, wasn’t getting anywhere on the phone.” Another Senior Officer, SO L, also recalls being in or around the office when these phone calls were being made. She was based on C4 unit but had come to D3 to assist with another prisoner who was causing problems. She remembers vaguely Ana having some sort of problem with her boyfriend and “I think he’d maybe got another woman and she was in the house or something like that. I don’t know if they’d got a dog or something that was mentioned. But she wasn’t very happy with him on the phone.”

SO L recalls Ana being angry rather than upset. “I mean she seemed annoyed. She didn’t seem distressed in particular. She was just <u>really</u> angry with him, you know, rather than be crying her eyes out and. She was just quite annoyed.”

Ana made a second call after which it seems that her mood had improved somewhat. Ana asked to make a third call but SO S told us that she "had obviously thought that we'd kind of resolved the matter then and with it probably not being commonplace for them to use the office phone, it would have been easier then the following day for her to get pin credit or get her a phone card and let her have a proper chat with him, what have you, but I didn't think a third call would've been beneficial, obviously." SO S told the internal inquiry that Ana was happier after the calls; G had assured Ana that it was not the case that he had found someone else – it was her family trying to split them up. SO S undertook to inform the staff working the next day about the situation.

A fellow prisoner told the internal inquiry that she was in the room when the call was made. She remembers Ana being upset – something about her dog. The fellow prisoner said that she herself spoke to G who was saying "that he loves her but he just wants to hurt her and stuff like that".

SO S told us that Ana "said that she loved me for sorting out all of her problems. So to me that was kind of closure on the matter. And I remember her skipping off down the landing."

Ana then went off to do her wing cleaning duties. She was a temporary wing cleaner, or at least assisting the other wing cleaners. It is not clear whether this was a formal job or a less formal arrangement. Officer D told the internal inquiry that Ana was in charge of the laundry. "She was the laundry cleaner and did a good job". She told us that the work involved cleaning, sweeping, mopping the landings, bathrooms and dining room but that Ana would have access to sheets. She told us that the wing cleaners tended to split their duties rather than work together. SO S told the internal inquiry that the wing cleaners usually work together.

Officer D did not see Ana again until around 18.45 "where she came to the office, she was quite calm, she asked for a cuddle – gave her a cuddle – she said she was carrying on with her work and she was gonna help {a fellow

prisoner} do suppers". She told the internal inquiry that Ana was clingy.

There was another prisoner on D3 who was causing difficulties. Officer D and Senior Officer L had been into her cell to remove a ligature and this prisoner was threatening to set fire to her cell. SO S told us however that she did not remember this particular prisoner causing any significant problems at that time "but she could've been ... it doesn't stand out as being something on my mind on that night." She told the internal inquiry, however, that concern about this other prisoner was one reason why she based herself on D3. Officer D recalled to us that she was on 15 minute observations. Officer D also had to admit a new prisoner onto the unit.

Officer D decided to find Ana to talk to her. She did not know where Ana was on the unit. She asked one of the other wing cleaners if she knew where Ana was. As Officer D turned around she saw a broom outside the bathroom and had a feeling something was wrong.

When Officer D walked into the bathroom she saw Ana lying face down with a ligature made out of a whole sheet around her neck. The other end of the sheet was around the handle of the toilet door according to Officer D. The internal inquiry stated that it was positioned over the top hinge of the door. Officer D shouted for SO S who did not acknowledge the call. Officer D therefore ran back to the door and asked the wing cleaner to get her. Officer D then returned to the bathroom, reached for her ligature knife but found that it was not there. She lifted Ana up with her left arm, undid the knot and radioed for assistance.

Although there is some difference of opinion as to exactly how the alarm was first raised, all reports agree that it was Officer D, as the first on the scene, who raised the alarm. Most respondents state that it was a radio call that was made. Only one Officer (T) and a Nurse (V) told us that it was an alarm bell that was activated (although at her interview with the internal inquiry, Officer T said she responded to a radio call and stated in response to a question from him, that "it was not a general alarm just came out over the radio") and Nurse

V stated at her interview with the internal inquiry that she responded to a radio call.

One of the prisoners on the unit said to the internal inquiry that she pressed the alarm in response to a request from Officer D. The entry in the Control Room log just records it as “Assistance Required D3” at 19.00. This would seem to confirm that it was a radio call that was made as it seems likely that it would have been recorded as “General Alarm” had it just been that the alarm was activated.

There is a similar discrepancy over exactly what was said by Officer D and subsequently transmitted by the Control Room. She herself believes that she transmitted the message: “Assistance requested D3” but was subsequently told (it is not recorded by whom) that she said: “Urgent Assistance”. The message she believes she transmitted is exactly as it is recorded in the Control Room log (although a separate unsigned, undated memorandum attached to the log records it as: “Urgent Assistance requested D3 unit”.)

In terms of the message sent out from the Control Room, there is a similar mixture of accounts. SO’s S and L simply state that they responded to a call for assistance over the radio (they do not recall what the message was). SO P said that the message was: “Urgent assistance required on D3 landing”. Officer T thinks that the message included something like “Medical emergency”, although at her interview with the internal inquiry she recalled that the message was: “Assistance required on D3 unit”. Sister W admitted that the passage of time had led to some confusion/loss of exact memory but she thought the message was something like: “Assistance – Medical Assistance required on Delta 3 unit” but at her interview with the internal inquiry she recalled that she heard on the radio a call for medical assistance and calling for Hotel 5 (her call sign). Nurse V said that she responded to a radio call: “A sister required on D3 unit” although subsequently said she responded to a general alarm. At her interview with the internal inquiry she recalled that the radio message was: "Assistance required on D3 unit” followed by another radio call requesting Hotel 6. Nurse N stated that she

responded to a call: “Hotel 6 to report immediately to D3 unit.” This was the same as she stated in her interview with the internal inquiry. The Principal Officer who was the most senior person in the prison at the time told the internal inquiry that she responded to a call for “Urgent Assistance” from D3 unit. She does not believe the general alarm was used. We have been unable to interview her as part of this investigation.

In May 2004 at Holloway there was no “code” system in operation to differentiate between the different types of incident that require assistance and so those who responded to the radio calls did not know what they would face when they arrived – a fight, assault, a hanging or other serious injury. The system has now changed with a simple colour code system meaning that those responding to the radio calls for assistance know the type of incident they will face. For example, a particular colour (code: red, blue etc.) will be used to tell staff that there is an incident of a particular type such as a prisoner hanging or a serious injury. This is particularly important for the medical staff to ensure they carry the correct equipment with them for the incident to which they are responding.

In this instance it would seem that all staff who responded arrived rapidly on the scene and that the absence of a code system in operation was not detrimental to the care Ana received.

Officer D managed to undo the ligature with her right hand and laid Ana down on the floor. She did not have her ligature knife, having changed her trousers earlier. At this point SO S came in to the bathroom, having been alerted simultaneously by the radio call for assistance and the wing cleaner who had come to her office. Officer D checked for a pulse and could not detect one. SO S said that she and Officer D turned Ana over onto her back and inserted into her mouth the plastic mouthpiece SO S was carrying. She and the Principal Officer who was the third on the scene, performed mouth-to-mouth resuscitation and compressions on her chest. At much the same time, or possibly just beforehand, SO P arrived. He had been on C1 unit and responded to a call “Urgent assistance required”, arriving within a minute or

two. He found SO S and Officer D working on Ana and reports that they "were a bit panicky." He recalls feeling for a pulse and then working on the ambubag – the equipment linked to a small oxygen tank that is contained within a suitcase-size medical bag.

This medical bag was brought into the bathroom by one of the nurses who had arrived shortly after SO P. Nurse N had been on B3 sitting with Nurse V As Hotel 6 it was Nurse N's duty to respond to calls on D3. Nurse V decided to accompany her when they heard over their radios the first call for assistance. They walked the short distance towards D3, hurrying when they heard a subsequent call for Hotel 6 – the specific call for a Nurse. On arriving Nurse V knelt down and assisted with chest compressions while Nurse N went to the nurses' room along the corridor to obtain the ambubag.

Sister W, the crisis response nurse who had been on Level 5, arrived later almost certainly in response to a further specific call. SO L, who was based on C4, also arrived, as did Officer T who had been on C3.

The recollections of the precise tasks undertaken by the staff and the order in which they were carried out are understandably a little hazy but the accounts written on the day or on the following day by the Principal Officer, SO S, SO P and Sister W are all broadly consistent. SO L and Officer D took a log of events. It seems that SO S and Officer D were badly affected by the events and once other staff had arrived they withdrew from the bathroom. The accounts are broadly consistent that CPR and mouth-to-mouth resuscitation was commenced and followed by the deployment of oxygen from the ambubag. Sister W told us that oxygen was being deployed by the time she arrived at the scene.

A defibrillator was requested by Officer D at the suggestion of SO P and brought up to the scene from H1 by the nurse based there. This was attached but no shocks were administered. The response by the staff and nurses led to

a pulse being detected and Ana resuming breathing.

The ambulance was called promptly, although the Principal Officer said that it appeared to take a long time. The control room log records “OS1 requests ambulance” at 19.03 and that it arrived at 19.15. The paramedics took over and Ana was taken to the waiting ambulance which left the prison at 19.55.

One different account is given by then Officer T who had been stationed on C3 and said that she responded to the call for assistance and arrived third on the scene. She said she found the two officers either side of Ana “and they were like, “She’s gone. She’s gone.” I mean they were in a right bad way. And I went, “Well, we’ll see.” you know, because I was calmer.”

She reports that the Principal Officer arrived then and started compressions and put a vent aid in her mouth. Thus far her account is consistent with others. She then says that a nurse arrived but the equipment she brought did not have oxygen in it. Officer T recalls the Duty Governor screaming at the nurses to go and get oxygen – but that by the time the nurses returned the paramedics had arrived and applied their own oxygen.

This account does not appear wholly reliable. The Duty Governor told us he did not arrive at the prison until considerably later. The Control Room Log shows that he was not informed about the incident until 19.10 and he probably did not arrive on the scene until 19.20. When he arrived the ambulance team were already on the landing working on Ana. He went on to explain that “Sister W had been administering oxygen but the paramedics had just taken over. I’m almost certain from the debrief that Sister W stated that she’d administered oxygen.”

None of the three nurses mention any problem with oxygen. Nurse V said that the nurse fetched the blue bag from the nurses’ office next door which had oxygen which was then applied through the ambubag. Sister W said that when she arrived on the scene oxygen was being administered and that the defibrillator was connected to measure output – but not used to defibrillate.

The log prepared at the time does record that oxygen was given at 19.04 and then that an oxygen saturation unit requested by Officer D on instructions; at 19.13 it records that a nurse arrived with a saturation unit. It is possible that this in fact refers to the defibrillator which was brought up from H1 unit.

Officer T told us that she had written down her concerns about the oxygen. We have not found any record of this, nor of any notes of the hot debrief which took place after the incident. Officer T told the internal inquiry that she was not asked to write anything. We do not find her account of what happened in respect of the oxygen a convincing one.

Chapter Nine

May 2nd 2004 to the present

At 19.55 hours, the ambulance left Holloway. Ana was taken to the Whittington Hospital. Two staff members accompanied her in the ambulance. The shower area was sealed and a hot debrief was held by the Duty Governor.

At 22.35 hours the contact number of next of kin was identified from the pin phone system. Mr A, Ana's close friend, was telephoned and agreed to attend the hospital. The Duty Governor and Deputy Governor of the Prison met him there at approximately 23.50. At 01.00 the next morning Ana was transferred to the Middlesex Hospital with two Holloway staff and Mr A in attendance. The staff were stood down the next morning and compassionate temporary release arrangements were put in place.

The police were informed about the incident at 01.35 on May 3rd.

Mr A had contacted Ana's "aunt" in Spain and she arrived on May 4th. He also tried without success to contact Ana's boyfriend. A number of Holloway staff visited Ana in the days after the incident. One of the Governors met Ana's "aunt" at the hospital and learned that she was in fact Ana's mother. Ana's mother visited Holloway a few days later.

Ana was transferred to the Royal Hospital for Neuro-Disability on November 3rd 2004. Ana has never regained consciousness and remains in a presumed persistent vegetative state due to brain injury sustained during cardio-respiratory arrest following the hanging. An assessment undertaken on December 13th 2008 concluded that her condition is unlikely to change in the foreseeable future.

Part Three: The issues the investigation examined, consideration and findings

Chapter Ten

Holloway in 2003-4

There is no doubt that during Ana's period in Holloway, the prison was struggling. The then Deputy Governor described the prison as "coming out of a desperate place and still a long way off from being a safe and decent place". Another Governor who was the Duty Governor on the 2nd may 2004 described it as "Crisis management on a daily basis". Senior Officer P thought it was "chaotic… there was a lot of chaos. There was a big change going on, a lot of changes in lots of different areas, lots of staff moving around 'cause of shortages of staff. I think a lot of staff working a lot of long hours. So I just think it was kind of going through very big upheaval that everybody was going through upheaval."

The Chief Inspector of Prisons inspected Holloway from October 4th-8th 2004. In her report (published in January 2005) she comments that the prison was improving from its low base when the last inspection took place (July 2002).

The period immediately before Ana's act of life-threatening self-harm on May 2nd 2004 was difficult. For the then Deputy Governor "we'd just been having the most desperate time".

According to the then Suicide Prevention Coordinator, "at that time, the average 2052SHs open on any given day averaged about fifty-five."

The annual reports from the Forensic Psychology Department show that in the period from March 26th 2004 to March 24th 2005, a total of 991 incidents of self-harm were reported compared to 897 in 2003-4.

The highest number of reported incidents was on Sundays (15%) although there was very little difference in the distribution of incidents. Indeed the self-harm annual report for 2003 found that the lowest numbers of incidents were reported on Sundays. Self-strangulation was the most frequently occurring method in 2004-5 accounting for 45% of cases. In 2003 the most frequently occurring method of self-harm was cutting (43%), followed by strangulation (26%).

Chapter Eleven

Why was there such a delay in the court process?

Ana was remanded into custody at Isleworth Crown Court on June 25th 2003, having been found guilty of offences of supplying drugs and wounding. It has not been possible to assess the reasonableness of the court's decision to remand her to custody, nor whether any alternatives (such as conditional bail) were proposed. It was Ana's first time in prison and, notwithstanding the seriousness of the charges, it might be expected that for a young woman of her age some form of alternative to custodial remand might have been explored.

The majority of Ana's time in prison was on remand awaiting trial and then awaiting sentence – she was sentenced on February 20th 2004.

There appear to be two reasons for such a lengthy delay between Ana's admission to Holloway and her being sentenced. The first is that on August 11th 2003 she was charged with a fresh offence relating to intimidation of a witness. The offence was alleged to have taken place on June 25th during the court hearing at Isleworth Crown Court. This charge was eventually dropped in February 2004.

The second reason is that that her case was adjourned for a series of reports. A Pre-Sentence Report was requested by the court on August 19th and completed on September 9th 2003. A psychiatric report was then requested. It is not totally clear how this was commissioned. It required an interview to be undertaken by a psychiatrist on November 10th 2003. This report recommended that sentencing be adjourned for at least six weeks to enable further assessment (by forensic psychiatric services in Ana's catchment area) to consider the need for admission to a Regional Medium Secure Unit for a period of in-patient assessment. This further assessment by the local forensic psychiatric services was undertaken on February 4th 2004. This concluded that Ana's level of distress did not warrant transfer to a psychiatric unit but

that, should her condition deteriorate, reassessment and consideration of transfer might be warranted.

We recognise the importance of psychiatric assessments and the diversion wherever possible from prison of remanded and sentenced prisoners suffering from mental health problems which can more appropriately be dealt with in a hospital setting. However we are concerned at the length of time this process took in this case and the outcome.

We recommend that assessments for transfer to psychiatric care are made very much more quickly than in Ana's case. We endorse the recommendation in Lord Bradley's 2009 report on people with mental health problems or learning disabilities in the criminal justice system that the Department of Health should develop a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting.

Chapter Twelve

What was the nature of the assessment and sentence-planning for Ana?

a) On remand and after sentence

As described in part one, there was little in the way of overall assessment and planning in respect of Ana's time in Holloway. The comment from one of the Governors in his interview with us that "Around about that time, things probably weren't as structured" is probably an understatement.

When HM Inspector of Prisons inspected Holloway in July 2002, "sentence planning was virtually non-existent".The position was better when the Inspectorate returned in October 2004 but they reported that there was still some work needed to provide coherent custody plans for those on remand and those serving less than 12 months and that "there was no form of custody planning for remanded prisoners".

For sentenced prisoners, the OASys Offender Assessment System was introduced in 2004 but it is not clear at what point during that year. The circular PSO 2205 – OASys, issued on July 10th 2003, says that OASys should have been introduced into the women's estate in 2003 but slippage may be possible. Holloway told us that OASys was introduced "in early 2004 but at the time of the serious self-harm incident, the system was only looking at women serving more than 12 months." At this stage Ana did fall into that category but no OASys assessment appears to have been undertaken when she was finally sentenced.

Prior to the introduction of OASys, the assessment of and sentence planning for prisoners was subject to PSO 2200. This set out a detailed set of requirements for assessment and sentence planning in order to prepare for a safer release and make use of the prisoner's time. This appears not to have been done for Ana despite after February 2004 her falling into one of the categories for which sentence planning was a requirement – that is a young

offender with at least four weeks left to serve.

There is one reference in the records to a sentence plan. After being sentenced, Ana was reportedly anxious about being transferred. The Area Manager agreed she could stay at Holloway if she kept to her sentence plan, but this is likely to have been a formulaic response. The Prison Service has not been able to find any plan (or any paper work relating to the decision.) So the basis of the decision to allow Ana to remain at Holloway after being sentenced is not entirely clear.

Some assessments of Ana were undertaken, as follows. On arrival she was subject to the First Reception Health Screen, in which she stated she previously suffered from paranoid schizophrenia, had inflicted cuts to her own face and that her brother attempted suicide. A cell-sharing risk assessment was completed on the same day. This says that Ana states she "is not and has never been suicidal or self-harmed". No one seems to have picked up on this contradiction.

A Pre-Sentence Report was prepared on September 9th by a Probation Officer following one interview at the prison. This states that "Ana has experienced what appear to be cannabis induced psychosis, this has involved auditory hallucinations and feelings of paranoia. She has received psychiatric treatment in the past and tells me that she has attempted suicide in recent months". But this information, whether true or not, does not seem to have been made use of by the prison.

There were assessment activities undertaken during Ana's periods subject to F2052SH in July 2003 and April 2004. A Mental Health Assessment was undertaken on April 20th 2004. This concluded with a plan which is probably the closest that there was to a sentence plan during Ana's time in Holloway. But the overall assessment of Ana's needs, strengths and plans for the future was very weak. The then Deputy Governor told us "It was just a complete shock actually of how little we did know of her".

Some members of staff told us that they talked to Ana. One of the SO's , SO K said "Shanie was often very open and talked to you about, about her life and obviously now we know that a lot of that wasn't true, but, I myself had many long conversations with Shanie in the office where she would open up and talk about stuff that she, she found painful." The then Residential Manager whose responsibilities included D3 and whose office at the time was close to Ana's cell on D3, also recalls conversations with her.

But there was no overarching approach to assessing Ana's needs, planning proactive work to address them or monitoring her progress. While many staff appeared to talk to Ana and form a view about her, this was based on rather superficial contact and observation. Other sources of information about Ana were neglected. Although it is easy to say in hindsight, the very heavy use of the telephone might have alerted staff to problems she was experiencing with friends and family. The Residential Manager then responsible for D3 told us that he thought it should have done so.

There was no Personal Officer scheme in operation at the time. The HMCIP described in its October 2004 report what such a scheme should involve. "Personal Officers should introduce themselves to prisoners, get to know their personal circumstances and record contact in wing files regularly to build up an accurate chronological account of a woman's time at Holloway and any significant events affecting her inside or outside prison". The follow up inspection in 2008 had to repeat a recommendation that an effective Personal Officer scheme should be developed across the prison because although there was a formal Personal Officer Scheme with a policy statement and guidance dated May 2007, "in practice the scheme was not fully effective". The current Deputy Governor at Holloway, who was a Residential Manager at the time of the incident, told us that Personal Officer Schemes are notoriously difficult to run in local prisons because of the churn and turnover of women.

It does not appear that by May 2nd 2004 any formal planning process had been made for Ana's release. The earliest date of release subject to electronic tagging would have been August 18th – some 15 weeks after the incident of

life-threatening self-harm. The Probation Officer, who compiled the Pre-Sentence Report, explained that that an assessment of suitability for release on Home Detention Curfew would not have been undertaken until a few weeks before the release date. It was due to be undertaken in June 2004.

The Residential Manager responsible for D3 and a number of other residential units at the time, reports informal conversations about the future. He recollects Ana "talking about wanting to be released to a different area to avoid the drugs issues that she had come from before."

There is some suggestion that anxiety about her future might have contributed to her state of mind in the period leading up to the self-harm. On April 18th she said she felt overwhelmed with the unknown when she would be released in three months. The Residential Manager responsible for D3 recalls Ana saying to him that "I get more in here than I would get outside. If we carry on like this I won't wanna go home." But he did not feel she was "overly concerned".

The HMCIP report in October 2004 recommended (at HP50) that actively managed custody plans should be developed for all women not subject to formal sentence plan arrangements so that their resettlement needs are identified and met during their time at Holloway. OASys has now been introduced. The current Deputy Governor at Holloway told us that there are twelve officers working in it across the prison, compared to two or three in 2004 when he was a PO... The HMCIP's 2004 recommendation that a custody plan should be developed for prisoners so that needs identified at induction or after can be translated into targets had not been achieved when HMCIP returned in 2008. The HMCIP report in 2008 found no sentence or custody plans for prisoners serving less than 12 months or on remand.

We are critical of the lack of structured assessment in Ana's case and of the missed opportunities to help meet her needs. Furthermore it is not clear how far the situation has improved at Holloway in respect of cases like Ana's.

We recommend that urgent priority is given to developing and implementing a system of assessing the needs of remand prisoners and those with short periods to serve and a fully functioning Personal Officer scheme.

Chapter Thirteen

Was the medical care adequate?

Dr Ian Cumming concluded, in his review of Ana's clinical care undertaken for this investigation, that in terms of mental health, the most noticeable issue was the poor, almost absent, involvement by mental health services during her time in custody. Additionally he felt that it showed poor communication and integration between the various elements that delivered health care in the prison.

As for the quality of the medical care provided to Ana for both physical and mental problems, the prevailing diagnosis for Ana was one of paranoid schizophrenia. Dr Cumming says that it is worth stressing that the position that Ana had a mental illness during her time in custody was correct, although he would expect that, had some of the assessors known of her unreliability, they would have been less certain about diagnosis.

Before Ana had come to prison this condition had been identified in the community. As occurred frequently, her management and care was hampered by her poor engagement and her use of illegal drugs. Services were aware of and acknowledged her use of drugs but still believed that she had an underlying mental illness.

Ana's mental health difficulties were identified at her reception at Holloway but approaches to obtain information were not productive. The poor communication started with the failure to obtain the records from the GP. The surgery claimed no knowledge of Shanie Lequan. More could have been done to find the information that existed – information was obtained by the Psychiatrist who assessed Ana for the Court in November 2003 and thus it should have been possible by the health team at the prison. Had medical records been obtained, they would have indicated previous suicidal thoughts and attempts, such as the referral from the GP to the Hounslow Community Mental Health Team in October 2002 which makes reference to Ana taking a

box of Paracetamol before the summer, nearly jumping off a building and cutting herself in police custody.

Ana's next medical assessment was on July 16th 2003 and in the context of her F2052SH document being opened and the need for a medical assessment. This seems a little late in terms of usual timescale. It was at this point (around three weeks after being remanded) that she was put on an anti-depressant. The anti-depressant was taken on only a few occasions and Ana began to refuse it by July 28th 2003. No referral was made to the prison In-Reach team at this point and the only mental health plan was for counselling. Psychology had seen her a couple of days beforehand. It is not clear as to how this referral was made but presumably it was in the context of the F2052SH. The Mental Health Team was not involved at all during this F2052SH and, though not a necessary requirement, it contrasts with the approach in the later F2052SH where there was more involvement.

When seen by the Psychiatrist in November 2003 to prepare a report for court, Ana's symptoms persisted, and upon the belief that she was no longer using illegal drugs, he made the diagnosis of schizophrenia and additionally that she was depressed. The use of illegal drugs in prison is likely to be less relevant - mainly because her access would probably have been far less.

Ana had assessments by two psychiatrists – the first (who saw her on two occasions) to prepare a psychiatric report and the second in response to the referral for transfer generated from the first. Both assessments acknowledged substance misuse but confirmed that she had a mental illness and required intervention and treatment with an anti-psychotic.

Despite the finding of mental illness in the November 2003 assessment and commencement of treatment with an anti-psychotic, Ana appears still not to have become linked in with mental health services in the prison. It is not clear as to whether this assessment was just an assessment for the court or why the North London Forensic Service (NLFS) did not continue to monitor Ana – particularly when they had made a referral to a Regional Medium Secure Unit

to assess the need for her transfer to hospital. This might indicate and reflect the sessional approach of NLFS in delivering care.

The psychiatrist who assessed Ana in November 2003 appears to have been working with the North London Forensic Service and thus it would appear that Ana's management is an example of the integration difficulties highlighted by the report of the Inspectorate of Prisons on Holloway later in 2004. They found that:

"There was little integration between the clinical team from the CMHT and North London Forensic Service. In theory they provided secondary and tertiary care respectively, but there was little joint working or cross-referral."

The lack of joint working would seem to explain why Ana was not monitored or even brought to the attention of the CMHT. Dr Cumming expects that the service from NLFS may have had a strong requirement to deliver psychiatric reports rather than address care and management. Both the psychiatrists who assessed Ana, in November 2003 and February 2004 did prescribe medication to Ana however.

The psychiatric issues do not seem to have been pulled together by anyone until the November assessment. Ana was concerned about the content of her conversation with him being passed on to prison officers as this would alter the way she was treated. The Psychiatrist was also not clear about how to proceed in terms of medication and discussed this with his supervising consultant. He then wrote a prescription for an anti-psychotic on November 25th 2003 but Ana appears to have only taken two doses before a series of 'R' entries were made – R stands for refused.

We asked one of the nurses what happens if a patient refuses their medication. She told us that "If she says to you "Oh, I don't wanna take them." there's nothing you can do, but, you know, document or report to the doctor that she – or make a comment in the column, where you should have signed

that she's taken them, that she hasn't taken them." She told us that, as the records in large part confirm, Ana "never used to take her medication".

The prescription was continued until December 22nd 2003 though Ana had not taken the medication since November 26th 2003. Again her non-compliance appears not to have triggered a response. It remains unclear as to whether prison In-Reach were aware of her presence and this indicates a separate approach by, and lack of integration between, the various elements of mental health – namely NLFS, prison In-Reach and psychology. The psychiatric report prepared in November 2003 appears to have been placed with the medical record after the Psychiatrist's second interview with Ana on November 29th 2003, but this still did not generate a referral or the engagement of mental health services at the prison.

It was not until February 4th 2004 that she had her next contact with mental health services in the form of the assessment by the Psychiatrist from the Tony Hillis Wing at St Bernard's Hospital. Although he noted that she had a psychotic illness, he did not recommend her transfer to the unit. He appears to have recognised the importance of her having medication and linking Ana in with the In-Reach team – thus he copied the report/assessment to them. Once more this did not generate any input from the In-Reach team. Nor did it generate any response from the NLFS and may indicate that each was of the view that the other was taking the lead. The Psychiatrist from the Tony Hillis Wing at St Bernard's Hospital again started her on medication – the prescription suggests that it was he who signed for the prescription and that it should continue (written in capitals). This was continued, it seems by the GP. Looking at the prescription it would appear that Ana did not take the medication at all.

Looking at the treatment – it would appear that despite a history of mental illness and two psychiatric assessments confirming this, Ana only had a handful of doses of an anti-psychotic in her entire time in the prison.

Once more there is separateness between the various health elements, including also the GP and nursing contingent employed by the prison. Her failure to take the medication again did not lead to any form of response from either NLFS or the prison In-Reach team. The issue was identified within her medical record on April 3rd 2004 but again did not generate any response beyond suggesting that Ana let people know when she wanted to take her medication. This completely handed over responsibility for her mental health to Ana and seems poor and risky particularly when she had a history of non-engagement and was presumably psychotic. It is a good example of why mental health services should have been involved to monitor her mental state.

Prison In-Reach did not become involved with Ana until the second F2052SH document was opened in April 2004. The Mental Health Team was asked to be involved on April 18th 2004 and assessed Ana on April 20th 2004. The entry in the medical record states the main concerns are “the physical health as opposed to mental health”. All of the contact with Ana by the mental health team was within the context of the F2052SH when she was seen on April 20th, 23rd and 27th 2004. Entries were made in the F2052SH document on all three occasions. An entry in her medical record was also made on April 20th 2004 and this would have been a time when there would have been some opportunity to see the psychiatric assessments by NLFS and the Tony Hillis Unit which would have been contained in her medical record. In any event the focus of prison In-Reach did not identify a history of mental illness and noted that none was present at that time.

Overall Dr Cumming feels that it is likely that the prison In-Reach team viewed Ana as having a physical health need with some accompanying emotional and self-harm issues. Certainly the involvement by In-Reach was entirely during the F2052SH period and indicates that they identified self-harm as the single issue. The suggestion in the report by the Psychiatrist from the Tony Hillis Wing at St Bernard’s Hospital of February 4th 2004 that Ana “may warrant reassessment and consideration of transfer” (to psychiatric hospital) should her condition deteriorate was not taken up.

Overall her decision to not eat in that period strikes Dr Cumming as odd. Preceding it and accompanying it were some mood changes and he would not discount that a depressed condition was a driver – particularly when one considers that her release from prison was looming. It seems likely that she also responded to external events and triggers, such as concerns about the relationship with her boyfriend, indicated by the large number of attempted phone calls made during April 2004.

There is a lack of a more developed understanding of this period when she did not eat or drink. Matters escalated significantly over the period before she was transferred out for a hospital assessment on April 21st 2004 and in the aftermath of this episode would have been an opportunity for a more considered view and potentially a case conference. The psychosis once more seems not to have been put into the mix despite various reports being in the medical record.

In summary Dr Cumming feels that the management of Ana's mental health care was inadequate; it suffered as a result of poor communication and integration within the provision at the prison. There is no information to suggest that this was due to a lack of resources and such issues around integration are a facet of many prisons.

There are however indications of wider problems in the provision of health care in Holloway at the time. The HMCIP Inspection report of an inspection carried out in October 2004 found that there was poor clinical and managerial leadership in some critical areas. At the time of the Inspection, both the Head of Healthcare and the lead nurse had been in post for over two years. This Investigation was told that there was an internal inquiry into Healthcare management which resulted in significant changes in the senior personnel in Healthcare, including the suspension of both of the senior figures. This is confirmed in a report by the Independent Monitoring Board but appears to have taken place in 2005.

According to HMCIP, mental health provision in the prison consisted of a community mental health team from Camden and Islington Mental Health Care Trust (two part-time senior managers, two community psychiatric nurses and two approved social workers), a consultant psychiatrist, two specialist registrars and a senior house officer who provided between one and five sessions each per week. In addition, a visiting professor carried out two sessions a week and consultant forensic psychiatrists and clinical psychologists from the North London Forensic Service saw prisoners with mental health needs whose index offence was forensic in nature.

It was noted that each prisoner on the CMHT caseload had a named team member but none were subject to the “care programme approach” because the psychiatrists who visited the prison did so sessionally and were not responsible for the care of the prisoners as resident medical officer. It was also noted that there was no specific mental health provision for the young prisoners although there were links with the local adolescent mental health out-reach team.

As for the current situation, the HMCIP in 2008 report found that health services were generally improved. “However women expressed dissatisfaction with the quality of healthcare.”

We are critical of the quality, consistency and integration of the medical care provide to Ana in Holloway. In particular given her psychiatric history and the opportunities to provide a sustained programme of treatment, the failure of the In-Reach team to take an interest in her case until she had been in prison for so long is hard to understand.

We recommend that more effective models of clinical care are developed for prisoners with diagnosed mental illness and that ways are found to ensure that diagnostic assessments undertaken for the courts are swiftly and systematically used to inform decisions about day to day medical care in prison.

Chapter Fourteen

Was information shared appropriately?

We have commented on the absence of an overarching assessment and management system for Ana in chapter twelve and chapter thirteen has described the poor communication between different parts of the health care services working in Holloway. There are some broader questions about information that arise from this investigation.

The first arises from the way in which Ana was able to sustain her false identity and maintain the stories about her past and current circumstances. The second is a question about the appropriateness of sharing of information about her mental health beyond the health care professionals.

On the first question it seems clear that Ana was, in the words of the then Head of Residence at Holloway "a hundred per cent convincing". One of the D3 officers recalled that "she would speak about her Mum" but it seems that as far as professionals were concerned Ana generally gave a consistent story which included the fiction that her mother was dead and her closest relative was an aunt in Spain. The Residential Manager responsible for D3 at the time suggested that Ana's mother might have colluded in this story. This is strongly denied by Ana's mother.

On the other hand, within days of arriving, the F2052A records that "Shanie has got a habit of lying and she is very realistic. Staff just beware."

Could Holloway have done anything to find out the truth about Ana? We were told that contacts were made with other agencies to try to verify her age. But as far as other agencies were concerned the person concerned was Shanie Lequan. Any efforts that Holloway could reasonably make to triangulate information about her name and situation would have confirmed the picture that Ana presented. If it lies anywhere, the weakness appears to lie with the

police who were prepared to accept Ana's name without question.

Regarding the responsibility of the prison, it is the case that little effort was made to assemble and substantiate basic information, including next of kin. Pursuing even this fundamental information might have enabled Holloway to discover more about Ana which might have helped to alleviate her situation. PSO 4600 on Unconvicted, Unsentenced and Civil Prisoners states that "Efforts should be made particularly during the reception and first night screening processes to identify whom the prisoner considers next of kin. The establishment should have clear details as to who, in the following circumstances, the prisoner would wish them to contact." The "following circumstances" include in respect of all prisoners "all cases of death, serious injury or removal to hospital on account of mental disorder, irrespective of any wishes the prisoner may previously have expressed."

It is also the case that little or no effort was made to identify and talk to Ana about some of the inconsistencies and contradictions in the information she did provide. It is no doubt easier to observe these with hindsight than at the time, but the fact is that the paperwork includes two different addresses for Ana; contradictory information about her history of suicide attempts; confusion about who was her brother, her step-brother, her boyfriend and her close friend.

It is perhaps inevitable and probably desirable that assessments rely in large part on what the person being assessed chooses to tell the authorities. Should Ana have been allocated a Personal Officer, it is possible that some of the inconsistencies in her accounts would have come to light and formed the basis of a fuller and more accurate picture of her needs. This might have provided an answer to the question posed by Ana's brother in his interview with us: "Was there no way of knowing who she really was?"

We recommend that stronger efforts are made to assemble and substantiate basic information about prisoners' next of kin and family situation, particularly where young offenders are concerned.

It is clear (see Chapter Six above) that staff were unaware of Ana's mental health problems and that she had a diagnosed condition. Our interviews with staff confirm this. The then Deputy Governor did not know she was suffering from a mental illness. The Principal Officer who was in charge of D3, went further and said Ana was not mentally ill – "absolutely not ..no evidence". The Head of Residence "only ever knew Shanie being both physically and mentally very well. But there was never, ever, you know, thinking about Shanie, never, never, ever had any concerns around her - her mental health." The first she knew about the diagnosis was during the preparation for being interviewed by this investigation.

We have described how staff were completely shocked by the incident, one being "completely blown away" when she heard the news and never ever having thought Shanie would have harmed herself. The PO in charge of D3 said that "Nine out of ten times we can see it coming."

The question is whether staff should have been so surprised. We asked a number of our interviewees if information about Ana's medical condition should have been more widely shared.

In his report prepared for the court, the Psychiatrist notes that Ana did not want the details of her interview noted as she was concerned that prison officers would know of her mental health history and that this would alter the way that she was treated. But it does not appear that the staff's failure to know about Ana's mental health difficulties resulted from a conscious decision to respect medical confidentiality.

There was a variety of views expressed to us about what should happen in respect of medical information and what did happen in practice. The policy on sharing information appears to be found in PSI 25/2002. This states that "Disclosure of confidential information should normally only take place with the consent of the individual concerned. Individuals should be made aware of

the uses to which their information will be put and with whom it will be shared."

Information can be shared without consent if it is required by statute or a court order. Disclosure without consent can also be made in exceptional circumstances if it is considered essential to protect the individual or anyone else from risk of death or serious harm, or for the prevention, detection or prosecution of serious crime. In such circumstances, the benefits of disclosing the information must be considered to outweigh the patient's or the public interest in keeping the information confidential. Health information is normally collected from patients in confidence, and the common law duty of confidence prohibits the use and disclosure of such information without consent.

Consent implies both choice and understanding. "Consent" given under duress or coercion is not, in fact consent. "Consent" given without a reasonable understanding of the purposes for which information is to be processed and of the type and purposes of disclosures envisaged is equally invalid.

If an individual wants information about them to be withheld from an agency which might otherwise have expected to receive it, the individual's wishes should be respected unless there are exceptional circumstances. Every effort should be made to explain to the individual the consequences for care and planning, but the final decision should rest with the individual.

One of the Governors acknowledged an issue of medical confidentiality but said to us that:

"I think Discipline Staff… the staff who dealt with Shanie on a daily basis would have been aware of that… They would have been aware of it. Medical records, IMRs are confidential, but Shanie would have… There's no secrets. Regular staff would've been aware of her medical background."

The Suicide Prevention Coordinator had a slightly different recollection: “From what I recall, I don’t think we were told about mental health problems. I mean the staff may have assumed they had mental health problems, but, I think there was patient confidentiality, between the Healthcare and the prisoner, unless the prisoner actually told them, you know. I don’t think there was, I don’t think the, Healthcare staff would come along and say, “Prisoner A’s got mental health problems, so you need to keep an eye on her.”

Nurse N said to us that it depended on where a prisoner was and their symptoms. “But if they are stable, no, we don’t discuss such a thing. But in the Healthcare, where the officers and the nurses sign a consent form, to say that, everything shared in there is confidential.”

If someone on D3 was suffering from mental health problems and was under medical supervision Officer J said “Oh, we would know about it.” SO P took a different view “At the time we, we weren’t allowed to share anything unless it was something which would put someone in danger or was very contagious.” Then SO K who worked on D3 thought “their medical stuff is confidential, so they wouldn’t necessarily be able to tell us.”

Whatever the issues of medical confidentiality, which we think need to be clarified, most of the managers told us that Discipline Staff ought to know about prisoners on their units with serious mental health conditions.

The then Head of Residence commented to us: “how can prison keep someone safe if you can’t share that information? Because absolutely if it’s mental illness then it affects everything in terms of risk. You know, risk to self, risk to others, helping them cope in custody, have the things they need. So from the individual’s needs being met, that’s the first, I think absolutely why we should.”

The Residential Manager with responsibility for D3 would have expected the Senior Officers on the Unit to know and the Officers on the Unit who would have dealt with Ana directly to know, and probably the Principal Officer.

His recollection is that communication “at that time... wasn’t very good”.

We think that the quality of care provided to Ana was adversely influenced by the limited information which staff, particularly those on D3 unit had about her mental health problems and that this raises important questions of principle and practice about the sharing of medical information.

We recommend that policy on the sharing of medical information in the prison setting is clarified and a training programme established to ensure staff understand its implications.

Chapter Fifteen

How well was Ana helped to maintain family contacts?

Although the staff at Holloway were not fully aware of Ana's family situation, they appreciated – as was the case – that she was isolated and lacking in support.

Staff made some efforts on Ana's behalf. When her visitor did not turn up on July 22nd 2003, while she was subject to the first F2052SH, the notes record that "Ana is devastated – spoke to visitor he was a bit blasé about it." An officer rang G/F when he did not turn up for a visit in December 2003. One of Ana's fellow prisoners also said she used to call him a lot of times.

The fact that staff did not know the truth about Ana's situation made it hard to support her. Officer D, who knew her well, did not know she had a boyfriend until May 2nd 2004.

What limited personal support Ana had was reduced further after her boyfriend was banned from visiting Holloway. The relationship was clearly a stormy and volatile one. The Chaplain told us that on May 2nd 2004 his conversation with Ana revolved around her boyfriend starting a relationship with another woman, recalling that she said "she'd actually done something very similar to him when he was in prison."

As described in Chapter Six, the ban followed a serious incident on February 19th 2004 in which the boyfriend threatened and abused staff and broke a glass door. It is not clear whether, and if so when, the decision to ban Ana's boyfriend from visits was communicated to Ana. Her boyfriend was sent a letter informing him that he was banned. There is a suggestion that this ban was extended from three months to a permanent ban. It is not clear whether Ana knew that the ban had been imposed or for how long, although we were told that prisoners get a letter about bans issued to their visitors. We have not seen such a letter in this case.

The criteria for banning visitors are set out in two PSOs, one relating to drugs and the PSO 4410 relating to more general matters. The latter states that "Any Visitor refused entry under the provisions should be informed of the reasons for this decision and of any avenues of appeal." This was not followed in this case because the letter included no information about appealing against the decision.

The Residential Manager responsible for D3 at the time of the incident explained the position: "the most you ban someone for is three months and then reviewed it after three months, and then you would review it monthly after that. It… If someone brought… had actually assaulted a member of staff and caused some serious injury then maybe we would have considered, but I don't believe that was the case, at all, um, and you would always review it. It would normally be for a set period of three months and that was certainly what the guidelines were at that time and they haven't changed since."

Staff members at Holloway were aware of the importance of contacts for Ana. Officer D told us that "She could be very emotional - especially if she couldn't get through to family on the phone. I understood that, along with the other officers. It must be frustrating."

The then Residential Manager told us that he had allowed Ana extra phone credit at one point because she had not been able to contact her boyfriend. But there was little systematic effort to involve family and friends in Ana's care and management – even when she was subject to the two periods of monitoring on F2052SH. Involving families and friends was one of the ideas set out in Holloway's policy on suicide prevention.

It was suggested in the Internal Inquiry Report that perhaps Ana had sought to harm herself in order to be moved to hospital so that she would be able to see her boyfriend – and he would feel sympathy for her. This suggestion is based on the interview with one of Ana's fellow prisoners and friends who said as much, as did one of the Governors. It is possible that Ana hoped to, or

indeed was able to, see her boyfriend when she was taken to hospital on the evening of April 21st 2004. She made two short phone calls to him after the decision was made that she should go to hospital at 17.30 but there is no mention in the record about whether she saw him at the Whittington. She was allowed to phone him when she returned to Holloway at 00.40 the next morning and further allowed to use a Samaritan phone. It is possible that she was hoping to see him there but he did not come, however this is speculation.

One of the nurses said in her interview that Ana had told her that she needed to go out and sort things out; she wanted a day out of the prison. There is no evidence that Ana ever made an application to do this. But had there been a Personal Officer this is just the type of issue that might have been pursued.

We think more could have been done to assist Ana with her family problems during her ten months at Holloway and that greater consideration should have been given to the impact on her wellbeing of banning her boyfriend from visiting her.

We recommend that the banning of visitors should be a last resort and in the case of young offenders the implications of such bans are taken into account before imposing them. Prisoners should be told of bans and avenues of appeal made known to visitors and prisoners when bans are imposed.

Chapter 16

How well managed and communicated were Ana's periods on F2052SH from July 13th-28th 2003 and April 17th-29th 2004?

The First F2052SH

The first F2052 was appropriately opened and the entries show a sense of care and understanding of Ana. They indicate an increase in activity in relation to Ana and reviews were held regularly which involved a range of people including Ana herself. Dr Cumming notes a sense of separateness between the response to health care needs and the monitoring under F2052SH however.

The closure of the first F2052SH seemed appropriate and by that time on August 13th 2003 – four weeks after its initiation – the document had served its purpose. One can detect that the focus was often around loss and recommendations for counselling and bereavement counselling. This is of course not surprising as Ana repeatedly gave the reason for her unhappiness as being the loss of her mother.

Psychotic symptoms never seem to have surfaced at any time. Dr Cumming found this slightly unusual as, although the people were largely not mental health specialists, one might have expected that the range of symptoms identified by the psychiatrists in November 2003 and February 2004 would have shaped Ana's presentation. He considers that there could be several speculative explanations for this.

As for following up the plan made during this period, Ana reportedly declined her counselling session on August 13th 2003, saying that she would rather go to the gym, and was taken off the list.

The Second F2052SH

The second F2052SH was opened appropriately and for a period Ana was very low indeed. She did not eat for several days and ended up going to the Accident and Emergency Unit at hospital.

It is not clear whether Ana moved into a communal cell during this period. The F2052A file (but not the F2052SH) records Ana's distress being linked to being on her own in a single cell. **In our opinion, explicit consideration should have been given to the question of whether Ana should be moved to a communal cell and if it was, this should have been recorded.**

Given that the life-threatening self-harm took place just three days after the F2052SH was closed, the question arises of whether the closure was premature.

Dr Cumming judges that her immediate risk had wound down after her visit to hospital on April 21st 2004 following the period of not eating. The entries have a general trend of improvement and frequent comments of being back to her normal self. The staff had aided her improvement by providing more structure in the form of cleaning and laundry duties, which seem to have had a beneficial effect and had been welcomed by Ana herself. The support plan did not seek to involve the close family and/or friends, despite this being one of the ideas set out in Holloway's suicide prevention local procedural document.

The Health team in the form of a psychologist only attended a review meeting on April 17th 2004. There is a hand-written note scribbled across a report that mental health will attend the reviews but they did not do so, although as noted in Chapter Thirteen above, the Mental Health Team did assess Ana on April 20th 2004 and found her *not* to have symptoms of mental illness. The assessment recommended further exploration of the diagnosis and did not explicitly address the question of whether Ana should be transferred to psychiatric hospital – notwithstanding the suggestion made by the Psychiatrist

in his report on February 4th 2004 that this should be considered should Ana's condition deteriorate.

The Suicide Prevention Coordinator at the time told us about the logistical difficulties of arranging review meetings with all of the right people present. Having the same people present at each review was, according to SO K, who opened and closed the F2052SH, not a requirement of the F2052, but it is now of the replacement ACCT (Assessment, Care in Custody, and Teamwork) system.

Then SO K I told us that "I closed it and I justified why I've closed it…and probably would do the same in the same situation."

She admitted she was not however aware that during the period of the F2052SH Ana had been to an outside hospital following a period of not eating. When asked about this, then SO K said that "But that's her physical well-being…. That's nothing to do with her suicidal intention. She felt that the assessment of Ana's mental health ("Assessed Shanie. Shows no signs or symptoms of mental illness") and the fact that she was happy meant that she was no longer suicidal. The meeting at which the decision was taken to close the F2052SH was also attended by Ana and a Nursing Sister who was a regular D3 nurse.

Nurse V told the internal inquiry that she had seen Ana when she was subject to the F2052SH and assumed, when she attended the incident on May 2nd 2004, that she was still subject to it – "I thought at least it would have covered a longer period." She acknowledged however that Ana had not been suicidal when she saw her.

It is true that Ana's mood appeared to improve after her return from hospital, but it did not improve completely. The F2052SH log notes on the day before the closure say:

"Had a long face and I asked her what was the matter – she said "I just want

to go home, I have had enough." "I told her that she is going home soon but she still sounded bad." Later she was recorded as having cheered up and being much better.

There is a question we have not been able to resolve about whether Ana's period on F2052SH involved her moving to a different cell. The records appear to suggest that Ana relocated to a communal cell on April 21st 2004 and back to a single cell on May 1st 2004. It may be that the record of the move on April 21st 2004 referred only to a short period prior to her transfer to hospital and that on her return she was located back into a single cell. It is also possible that she stayed in a communal cell until May 1st 2004.

The Suicide Prevention Coordinator told us that one of the problems with the F2052SH scheme was the difficulty in bringing the period to a close. He considers the ACCT system which replaced the F2052 scheme to be better in this regard. In this case then SO K has little doubt that it was the right decision to close Ana's F2052SH on April 29th 2004.

Any suicide risk prevention system will become devalued if it is used inappropriately for example by keeping it open longer than necessary. Then SO K told us that at times there might be 12 young women on D3 subject to F2052SH. On May 2nd there were five, according to Officer D. The first 2052SH in July 2003 was open for four weeks compared to twelve days in the case of the second.

One further point that needs consideration is what happens after a period subject to F2052SH. Then SO K told us that once a 2052 was closed, although formal monitoring, recording and review would no longer be required, there would still be some heightened attention paid to the prisoner. "That care and that concern still goes on amongst staff."

The PSO 2700 is more specific and says that the case review which closes a F2052SH "will agree after care or follow up requirements". None seem to have been agreed in Ana's case.

Of the staff we spoke too, some were aware that Ana had been on a F2052SH shortly before the incident. Officer D said, “I think I was on leave, because I remember coming back and I was told, or I read in the Obs. Book an entry that said Ana had tied a ligature in a bathroom. But, I’ve been told that she was put on a 2052SH but now it had been closed.”

Officer J could not remember Ana being subject to this F2052SH. She said she “was surprised when I got the note” (referring to the papers she saw about the case in preparation for her interview). She said that “Well, if she, if she was on it, I would have known about it. But I can’t – I can’t remember thinking back that she was on that ACCT [sic] document.” She explained that all the staff on a unit would know “because it would be in the diary. Soon as you come in, soon as you come on duty, you would check the diary, check the ACCT documents and go round and <u>see</u> the person, just to make sure they were OK.”

The then Residential manger responsible for D3 said that “I don’t remember it, but I would have been aware of it because, you know, I went round and checked on them regularly and I am sure if the document was here and you checked you would find my signatures in it.”

SO S told us that on May 2nd she had no recollection of Ana having been on a F2052SH - although this is not surprising given that she did not work on the D3 unit.

Given the requirements associated with active F2052SH cases, it may not be reasonable to expect staff to give special consideration to those for whom this status is no longer active (however recently it has been closed).

Holloway appears to have introduced a more formal policy in respect of recently closed F2052SH cases later in 2004 – possibly as a response to Ana’s case.

We consider both periods on F2052SH to have been managed reasonably well but think that the serious physical problems experienced should have been taken into account when closing the second one. The support plan might have looked at ways of involving family or friends as set out in the local policy and should have contained more in the way of after care for the period following closure.

We recommend that physical as well as mental health is fully assessed during periods subject to suicide and self-harm monitoring and that consideration is always given to the most appropriate location for a prisoner, in particular whether a move to a dormitory is desirable and the outcome of such consideration recorded.

Chapter 17

Was the response to Ana on May 2nd 2004 adequate up until the incident?

The Duty Governor who was in charge of Holloway on May 2nd told us that:

“D3…was high profile that day because there was another prisoner on there who was self-harming, virtually hourly and staff had a horrendous day with her. I dealt with her on a couple occasions that day, in fact when I left the prison and I heard there had been an incident on D3 and I automatically assumed it was the particular prisoner. As it happened, it wasn’t.”

a) Staffing Levels

One of the key questions we have explored is whether the staffing levels were adequate to meet the needs of the prisoners, including Ana, on that day.

From the Central Detail Daily Resource Sheet it appears that on D3 on May 2nd there should have been four staff on duty during the morning and afternoon and two during evening duty which started between 4 and 5 pm. The overall number of staff who should have been in the prison during the evening duty period – when the prison was in so called patrol state (in which almost all the prisoners are locked up in their cells) – was 25. Another document entitled Staff Availability which appears to indicated profiled staff numbers gives a different picture suggesting that the profile for the morning was four staff but the number ‘4’ is crossed out and replaced with a handwritten ‘3’. For the afternoon a ‘3’ is replaced by a handwritten ‘2’. For ED (evening duty) the number is 1 (unaltered). However it seems clear that there were supposed to be two staff on D3 in the evening period.

On that day, the prison had four so-called bed watches. This means that four prisoners were outside prison in hospital. Generally each bed watch requires two staff. One of the YO unit staff, Officer J was part of the bed watch team. In

the evening duty period, D3 was therefore staffed by Officer D, a regular D3 officer and SO S, who normally worked in the prison's reception area.

SO S told us that in the afternoon she was Senior Officer in the Young Offenders Unit and detailed to be Assist Orderly Officer in the Evening Duty period. An Assist Orderly Officer is in effect the second in command. The Assist Orderly Officer is a relatively senior member of staff (a senior officer at Holloway) available across the prison to assist as necessary. They are available to respond to emergencies and deal with any queries raised by staff. By virtue of their duties, they can be called away from where they are located at any time and must remain mobile.

They will always be available via a radio call. SO S decided to stay in D3. SO S told us that her deployment to D3 was unusual and could not recall any other occasion in which she worked anywhere apart from reception. Given her prison-wide responsibilities SO S could have decided to base herself elsewhere in the prison – and could have been called to deal with incidents elsewhere at any time.

D3 had fifty six young women at that time with about twenty staff allocated to it. It was a demanding unit. Nurse V described it as "wild…there's always a lot of squabbles, fights and all that. A lot of times they are calling people. They raise the alarm – it's because there are people fighting, so they need people to help separate them."

On March 6th 2004, an officer who had undertaken evening duty wrote in the Staff Observation Book that "D3 had 55 women and 8 2052SH. I was left on the unit. D3 is a very unstable and volatile unit with young people with many different issues. I think it is dangerous to leave one member of staff on D3 as the unit cannot be manned properly in my opinion."

On May 1st 2004, the day before the incident, an officer commented in the book that "during nights this week there has been a lot of very emotional girls that have needed lots of support and extra observation through the night". The

entry goes on to comment about the suitability of certain cells for prisoners requiring regular observation, and suggests the high level of need among the residents of D3.

On the day in question, Sunday May 2nd, another prisoner on F2052SH who was tying ligatures was taking up a lot of staff time. Then Officer T said to us that she remembers Senior Officer S saying to her, "Shanie said she wanted to talk to me, you know, over and over, Shanie is wanting to talk. She's had a bad visit. And S had sort of said, 'In a minute, mate, because we've got to deal with this girl. And because of this, S felt really guilty that she hadn't got to talk to Shanie about her bad visit. Because of what they were dealing with, with not enough staff and this complete pain that shouldn't have even been on there, enabled Shanie to be able to disappear and do what she wanted to do and not get found as quick as possibly if you were wandering around wondering where she was."

SO S did not remember the other prisoner causing any significant problems at that time when she spoke to us "but she could've been." Her note on the incident says that "we called all Level SOs to go in to her room twice and cut things from her neck." Officer D told us that before the incident she wanted to spend more time with Ana "just to talk to her". Clearly her other duties precluded this.

Was the staffing adequate? Holloway does not appear to have had a minimum staffing level at the time. The minimum staffing level (MSL) is an agreed level of staffing needed at different times of the day and days of the week for different activities to occur. For example, there may be an MSL for prisoners to be allowed out on association and if that level is not reached then the unit will be on 'patrol' state, meaning that the prisoners will be locked in their cells. There can be an MSL for the establishment as a whole and if the staffing level falls below that minimum level then the governor can institute a "state of emergency" and order staff into the prison until that level is reached. Holloway's failure to have an MSL meant that it was up to the Duty Governor

of the day to determine whether the staffing level was adequate for the day's activities to occur.

Staff had different views according to the interviews they gave us. The then Deputy Governor did not have particular concerns about staffing levels - that is the number of staff who were supposed to be on duty at any one time. Staffing was difficult because of a high vacancy rate and the need for staff to be asked to come in at the weekend. Sickness levels were also high at Holloway at the time. The head of personnel reported to the POA/Management committee on June 10th 2004 that one fifth of staff were on sick leave at that point. The Head of Residence told us she "wasn't happy with generally the staffing levels."

The reality was of concern to the Governor who was on Duty on 2nd May 2004. He told us that "sometimes it's necessary to redeploy far below what you would consider to be safe manning levels and that was the case in question." Officer T who has since left the service agreed, telling us:

"There's no staff in that prison. I had the argument that there was a lady on A3 and me on C. We were covering a landing and a half each, which isn't safe. That's two hundred odd prisoners between the three. There's never enough staff on nights. In the <u>evenings</u>, not nights, the evening…. It's like the prison's hard enough, and then you don't get enough staff."

The current Deputy Governor, a Residential Manager at the time, by contrast thought that two members of staff on D3 were higher than he would have expected it to be.

Entries in the Staff Observation Book early in March 2004 show that there was no association on D3 on two consecutive evenings. The girls "were not happy about this situation – Majority of them requested for complaints form" but we have not been able to find out if Ana was one of those who made a complaint. Officer D told the internal inquiry that three staff were needed for association to take place and that they "don't always have three." Without

association girls would be locked up from 5 pm until 7.30 am the next morning. This was generally the position on Saturday and Sunday and is still the case.

Officer D thought that two people were needed in the patrol state. She said that if she had been on her own on D3 – a real possibility had the Assist Orderly Officer based themselves elsewhere in the prison – it would be "not really all right but I'd have to go along with it".

The Head of Residence thought that what would be ideal is "you could have one person and then a couple of people, certainly being able to roll through, and deal with other people. So if it had been Level Three for instance, you'd have had one on A3, one on B3, one on C3, two on D3 and then two or three as a little team who would've been able to go up and down and, and be able to get women out for a short period of time for a, you know, bit of conversation with each other, access to the phone – especially if they'd had a bad visit on a Sunday – you know, a quick bath. If you've had a visit on Sunday afternoon, been to church in the morning, actually you might not have had a chance to have a bath all day. That kind of thing would be absolutely ideal."

The demands made by bed watches make a particularly serious impact at Holloway. The Duty Governor on the 2nd May 2004 told us that "It was not unusual at any given time for six, eight, even ten prisoners, to be out, in outside hospital, with two staff at the bedside twenty-four hours a day and it is impossible to man a prison with… in those circumstances." He told the internal inquiry that "it's not satisfactory and unfortunately we don't have any option when bed watches go out at short notice."

The internal inquiry concluded that "whilst the provision of staff to cover hospital and bed watch escorts will remain an ongoing problem recommended that Holloway "should review its current method of allocating staff from these duties from residential areas, especially at weekends when staffing levels may be considerably reduced. It is hoped that an improved system might be identified which would reduce the impact of such escorts on residential area regimes allowing them to function as normal as possible and above all at the

intended Prisoner/Officer ratio identified in that Units staffing profile."

The Action plan produced after the incident recognised that at weekends, due to the reduced regime in the evenings, it is vital that every effort is made to maintain staffing levels. This form of words is repeated in the update on recommendations on October 26th 2004 and again on July 11th 2007. In a memo to the Governor updating her about the investigation into the AA case dated June 20th 2008, the Prison Community Manager, comments on the issue of removing staff from residential areas to cover bed watches: "I am concerned that while the issue may have been taken into consideration with the re-profile, there may not be a clear policy for implementation."

There is a cost of course to increasing staffing levels. The current Deputy Governor told us that "If you go to our other establishments, you might have one member of staff patrolling for three, four hundred people. So it does make us expensive and it's trying to address that balance."

We consider the staffing levels to have been too low at Holloway. On Saturdays and Sunday evenings when many women may have visits which might prove distressing for one reason or another, there is a need for women to be able to talk to staff.

We recommend that the adequacy of staffing levels is reviewed particularly in respect of the needs of women at weekends. We also recommend that stronger efforts are made to ensure residential units are not deprived of staff because of bed watches.

We further recommend that Holloway agrees a minimum staffing level and takes action when the level in any area and/or at any time is not reached.

b) The period until lock up

The staff in the visits area clearly picked up on Ana's distress and informed the unit staff. The intervention of the Chaplain appears to have been helpful. The fact that Ana asked to see him after Church (i.e. before her friend Mr A had visited that afternoon) suggests that Ana already knew or suspected that her relationship was over before the visit – a point which Mr A made to us.

The Chaplain was pleased that the staff decided that Ana should lodge with her friend. It appears that some of the staff had a discussion about how to respond to Ana but Officer D does not seem to have been part of this. She could not remember any formal discussion and told us she was not part of the decision that Ana should lodge with her friend. Officer J remembered that "she'd been upset about something and staff were talking about it. And I was busy locking and we had come back into the office. And then they were talking about, we were talking about Shanie. And staff were saying that, "We'll keep an eye on her tonight. We'll know. 'Cause she was a bit upset."

We think that a short discussion should have been held after Ana's return from visits on the afternoon of May 2nd, involving all staff to ensure they knew about Ana's distress and to agree a plan for managing it.

c) The period after Ana is unlocked.

A question arises about whether Ana should have been unlocked after the teatime period. The unit was now in patrol state. The current Deputy Governor told us that "the culture at Holloway is that they will have two or three people out, during patrol state." As a temporary or assistant wing cleaner, Ana would have expected to have been unlocked at this time. Officer D told us that Ana said she wanted to work and that she seemed quite calm.

After Ana was unlocked and before she commenced her wing cleaning duties, she was allowed to make two phone calls from the office. It has not been possible either for this investigation or the internal inquiry to find out directly what was said. This would have been possible if the calls had been made on

the PIN phone but as the Duty Governor said to us "if we wanted to know what was being said in the phone call the office is the right place because the staff are there." The Head of Residence thought in contrast "ideally... it would be additional pin credit rather than the office phone."

The Duty Governor also told us there was a procedure for granting phone calls. "They should and they would have certainly cleared it with the Orderly Officer. She would have authorised those phone calls. The Head of Residence agreed that "quite often we would give telephone calls but that that must be, approved by a Governor grade or a Duty Governor but then written in the history sheet, if I remember rightly."

SO S, who agreed that the calls could be made, took a different view "Well, it, again, it's at your own discretion. If you thought it was warranted and it was genuine, then, yes, you would."

Officer D suggested in her interview with the internal inquiry that this might have been a decision that she could have taken herself. While it would be desirable to be clear about what the procedure is, we have no doubt that it was the right decision to allow the phone calls. We also think that using the office phone enabled staff to hear at least one side of a difficult and emotional conversation and thereby provide support if necessary.

SO S judged that after two calls "we'd kind of resolved the matter then and with it probably not being commonplace for them to use the office phone, it would have been easier then the following day for her to get pin credit or get her a phone card and let her have a proper chat with him, what have you, but I didn't think a third call would've been beneficial." This does not seem unreasonable. SO L who had also heard the call told us that "there was nothing triggered in my head from that phone call that from my, from what I heard, to think, 'She's at risk'."

In the internal inquiry, one of the prisoners interviewed said that Ana had asked to be placed in a communal cell but Officer J refused the request. We

asked Officer J about this but she could not recall this request being made. It is possible that being low in mood Ana felt that she could not face a night on her own. She had asked to move into a dorm during the first period on F2052SH and it is not clear where she was located during the second period.

Given Ana's distress, the question arises whether a fresh F2052SH might have been opened on the afternoon or evening of May 2nd. The Holloway Suicide Policy in operation at the time states clearly that a F2052SH must be opened following all incidents of self-harm or at any other time that you feel the prisoner may be at risk of suicide or self-harm. It also lists the factors that place prisoners at risk and these include "bad visits / relationship breakdown". Indeed from the list of risk factors used at Holloway, Ana had seven of the listed risk factors (unhappy visit, breakdown of relationship, pessimism about the future, hopelessness, impending release, age less than 25 and history of drug abuse).

SO S told us that "If I had thought at the time that there was a risk of suicide or self-harm, then I would've taken the necessary action, i.e. putting them on an, an ACCT or a 2052 as it was, at the time." Officer D said that "maybe" she had considered this course of action. The Duty Governor told us that had the regular Senior Officer been on duty, I am sure she probably would have opened the 2052." Nurse N told us that "In such a case now, they just … an ACCT, ACCT would be opened and she'd get all the, all the help she could and then many people would speak to her: listeners and the counselling and an ACCT would be opened."

It is not clear exactly what difference opening the F2052SH would have made that afternoon and evening but it would have required more structured decision-making about Ana's care. PSO 2700 and Holloway's Suicide Prevention Local Procedural Document spell out what should have been done. The first of these says that as well as formally opening, recording and communicating the status, the unit manager must speak to the prisoner and initiating member of staff, consult health care and other relevant staff and check…particularly for previous F2052SHs, adding any relevant information

from it to the new F2052SH. They should decide whether to manage the prisoner on the residential unit or refer to the Health care centre. If the former they should take initial action to help the prisoner, ensure that where available prisoners are offered an opportunity to talk to a Listener or Samaritans. Holloway's local procedural document replicates this in large part, tasking the residential unit manager with ticking the type of location where they believe the prisoner should be managed.

Had a F2052SH been opened Ana would probably have been assessed by medical staff. Although it was a Sunday afternoon, Nurse N told us that one of her duties that day was to undertake assessments in these kinds of cases. It is difficult to say what such an assessment might have found and what action might have resulted. The Duty Governor said to us that the "Action Plan on the 2052 would be, probably exactly what the staff did anyway." The Residential manger responsible for D3 told us he thought it would not have made any difference to Officer D "whether she was on the 2052 or not. She would, you know, have given the same care."

Three particular matters might have been addressed had a F2052SH been opened.

First was the question of where Ana would be located that night. Having agreed to her request for shared accommodation in the short term that afternoon the staff might have considered more carefully the best place for her to stay that night – whether or not she made a specific request to move. As the duty Governor said to us "The options would be to put her in a dormitory, she didn't like dormitories, to put her on constant observations." PSO 2700 says that "at risk prisoners should be routinely allocated to shared accommodation unless the prisoner represents a risk to others, their behaviour is too disturbing to other prisoners or shared accommodation is not available" A review of Suicide and Self-Harm Prevention measures at Holloway carried out in July 2004 (prompted in part by Ana's case) expressed concern that in general prisoners on an open F2052SH were not

allocated to shared accommodation and recommended that this should be done more routinely.

The local policy document suggests, among ideas for developing a support plan, providing a cell change to allow for a more supportive mix of prisoners and where possible placing the prisoner in shared accommodation.

The second matter relates to the level of monitoring and observation. SO S said that if a F2052SH had been opened, “in subsequent hours she would’ve been checked on, which is what the F2052 was, at the time.” The Suicide Prevention Coordinator said to us that “I would expect, if a 2052SH was opened, that they would have had a review and set, observation limits, even if it was only for that night, pending a full review the next day.”

The third decision that might have been considered more carefully if a F2052SH had been opened, was the decision to allow Ana to work on her own. Ana’s mother finds it hard to understand why so shortly after being very distressed, her daughter was allowed to work unaccompanied and in particular given access to sheets when two weeks before Ana been found attempting to tie a ligature with one. Her brother told us that in his opinion she should not have been left on her own.

Ana had undertaken work as a cleaner and done the laundry on a number of occasions before May 2nd – including on the previous Sunday when the F2052SH was open, although this fact may have meant that her work was subject to some degree of supervision. The PSO 2700 makes it clear that an open F2052SH should not preclude movement around the prison. The Holloway procedure suggests that a support plan should include trying to keep the prisoner occupied by offering opportunities for work, association and/or other purposeful activities.

The Duty Governor on the 2nd May 2004 thinks that “the decision to get her out, running a normal routine as far as possible with other cleaners was

probably the right decision and the 2052 probably wouldn't have affected that at all."

However the Residential Manager responsible for D3 (who was not in the prison at the time) said "I don't think she was found quick enough and I think that's really the sad part of it."

An analysis of Ana's Inmate Medical record prepared as part of the Internal Investigation (dated July 14th 2004) concluded that "Given that an F2052SH had previously been opened and various urgent referrals regarding Shanie's mental state had been made, why, if staff (at 18.00 hrs) had observed Shanie being upset following a visit, during which she had been told that her boyfriend had ended the relationship, given her history of self-inflicted cuts to the face, expressions of suicidal ideation had they not considered re-opening a F2052SH or making an urgent referral to a duty doctor re her mental state."

We think on balance an F2052SH should have been opened on Ana on May 2nd 2004.

Working as normal would potentially have two positive effects. First, as the Suicide Prevention Coordinator told us, "it may be, because she was out cleaning, as opposed to being locked up, that the person on duty thought, "Well, I can keep a better eye on her."" Similarly the Duty Governor said that "They thought she'd be better out working in view of everybody."

Second, as the Suicide Prevention Coordinator also said "if she's actively working then perhaps it's taking her mind off her current problems. If she's also out of her cell, she also has the opportunity to approach the member of staff at any time of the night, hour and perhaps divulge a bit more information". Officer D told the internal inquiry that work was Ana's way of dealing with frustration.

Given that Ana had been found in a bathroom preparing a ligature with a sheet just two weeks before, the question arises as to whether staff should

have made a connection and prevented her having access to sheets. We discovered that following the death by hanging of another prisoner in April 2004 a review of bedding was undertaken at Holloway, but this did not consider the question of access to sheets, concentrating rather on the possible introduction of bedding which cannot be torn.

It is also clear that D3 was having problems coping with the laundry. An entry in the Staff Observation Book on April 19th 2004 notes that "every night this week the pile of bed linen was getting bigger and bigger and tonight was touching the ceiling."

It seems likely that SO S did not know precisely what the cleaning duties involved. She told the internal inquiry that they involved "just keeping the landing clean, handing out tea." Officer D told us that the work involved cleaning, sweeping, mopping the landings, bathrooms and dining area and also said that she would have access to sheets.

As for the overall management of Ana's case up until that point, the Duty Governor told us that he "was a little bit concerned that I hadn't been made aware of it but on that particular day. But there was a lot of things happening in the establishment… and staff probably felt they could deal with it themselves I don't think I'd done anything different, had I known about it."

We do not think that there was anything wrong in itself with the decision to allow Ana to work on the evening of May 2nd. We do however think that staff should have sought to supervise that work more closely and would have done so had a F2052SH been opened.

We recommend that when prisoners believed to be at risk are allowed to work, they should undertake tasks in the company of other prisoners rather than alone and that staff should supervise their work as much as possible.

Chapter Eighteen

The response to the incident

Ana was discovered by Officer D at about 18.55. Once the discovery was made, the question arises could anything more have been done which would have reduced the likelihood of serious harm, for example a quicker response, access to equipment which could have more quickly removed the ligature or more effective measures?

We have not been able to study a contingency plan for dealing with incidents of serious harm at Holloway so it is difficult to know what procedures should have been followed. We have been told that a contingency plan from 2004 does not exist so it is difficult to assess whether the response was appropriate. The sequence of events has been described in Part Two above. The main questions which we have considered relate to whether:

a) the ligature might have been released more quickly had Officer D been able to cut it with a knife rather than untie it.

b) the alarm system might have better indicated the nature of the incident and the type of assistance required.

c) the team that worked on Ana might have done so more effectively.

On the first point Officer D accepts that she should have been carrying a ligature knife but had changed her trousers and omitted to replace the knife. Holloway's suicide Prevention and Self-harm Management Strategy for 2008-9 requires all staff to carry on duty their own personal use cut-down tool but this was not the case in 2004. The local policy summary in force at the time describes how ligature tools are available in offices. But since Officer D was able to undo the ligature quickly, having a knife in this case is unlikely to have made a crucial difference.

On the second point, Nurse V told the internal inquiry that had the initial call been for medical assistance, then nursing staff might have arrived more quickly. In particular the nurse with the Hotel 5 call sign which was the crisis response – Sister W in this case – would have attended immediately without having been specifically requested to do so. Although Sister W initially told us that she responded to the first call it seems more likely that she responded to a subsequent one. Nurse N told the internal inquiry that had Sister W arrived sooner, a nurse could have taken over the mouth to mouth resuscitation from the Discipline Staff (in this case SO P). Nurse N pointed out that it was by chance that Nurse V was sitting with her when the call came. Had she not been in a position to accompany her to D3, then Nurse N who had the call sign Hotel 6 that day would have been the only nurse on the scene. This would have been inadequate given the need for a nurse to obtain the oxygen and ambubag from the nurses' station before being able to assist in resuscitation efforts.

The alarm system has been changed so that it is clearer what kind of incident is being alerted and to whom. A memo was sent to the Governing Governor in June 2008 saying that "the system has recently been amended and the notice to staff should be reissued to remind all staff of their responsibilities."

As for the overall response, Dr Cumming has noted that there is some discrepancy in terms of who did what and when. This is not uncommon in such a situation or within other emergency situations such as a "crash call" at a hospital. There are many factors which determine the outcome in cases where anoxia of the brain has occurred. He notes that there were concerns around whether or not oxygen was available and whether this might have made a difference.

Cardio-Pulmonary Resuscitation (CPR) replicates the heart pumping and the intake of oxygen into the body. There is likely to be considerable variation in how effective CPR is – it will depend upon the quality of the procedure among other matters.

Brain cells can only survive for a few minutes before they begin to die off. The timescale is not absolutely clear between when the ligature was tied, when Ana was found and when CPR was commenced. In view of her current level of functioning, it is highly likely that damage was already severe by the time Ana was found and that neither the presence of oxygen, nor the effectiveness of the CPR would have made much difference.

The response indicates that the absence of vital signs and a cyanosed appearance (indicative of a lack of oxygen) led to the delivery of CPR. The CPR seems to have been successful in that with the arrival of the nurses, who took over the chest compression, it led to an output from her heart. This was confirmed with the defibrillator, which provided confirmation of the output, and additionally Sister W noted that she had an output in the form of being able to record blood pressure. It does not appear however that Ana was able to breathe independently and thus the respiratory assistance continued.

We find the response to the incident on May 2nd was prompt from both discipline and medical staff.

Chapter Nineteen

How well did Holloway prevent suicide and self-harm?

HM Inspectorate of Prisons reported in 2004, the year of the incident of life-threatening self-harm, that there was a high level of incidents of self-harm and suicide at Holloway and that staff needed better training. There was little multi-disciplinary approach to care and a need for more meaningful specific support plans.

At the time there were an estimated 1,000 incidents of self-harm per year involving over 200 prisoners. Between January 1st and October 4th 2004, 777 F2052SH forms had been open with as many as 80 being open at one time.

The Inspection reported that there was a clear need for improved staff training in mental health issues, suicide prevention and First Aid. This is illustrated in this case by SO P who told the internal inquiry that he had not undertaken First Aid Training since 1997 or 1998.

Between October 2003 and September 2004, 135 staff had received some suicide prevention training. However, training was frequently cancelled. The Inspectorate reported that many reviews were not multi-disciplinary and were chaired by senior officers who had received no training in this task. They reported that they had little support from specialists and were left to make important decisions about the care of vulnerable individuals.

Staff training figures for June 2003 - June 2004 reveal that 74% of officers had received training in suicide prevention but only 4% of senior officers and 6% of healthcare staff had done so. A document listing staff who had completed training suggests that of those involved in the care of Ana on May 2nd, Officer D, Officer J and Nurse V had received training before that date and that SO S had not.

A review of Suicide and Self-harm Prevention measures at Holloway was

conducted shortly after the incident, reporting in July 2004. The review found that Holloway's local policy was not fully compliant with PSO 2700 and the volume of open F2052SH documents impacted on staff's abilities to maintain the system. 28 recommendations were made. The Suicide Prevention Coordinator at the time told us that Holloway did not come out of the review well although the troubling example he gave in his interview with us – that there were no Samaritan phones or they did not work – was not one of the review's findings.

At the follow-up inspection by HMCIP in March 2008 it was noted that the F2052SH system had been replaced by the ACCT system. It reported that the documentation was generally completed to a reasonable standard but most reviews were still not multi-disciplinary, care plans were not always sufficiently detailed and key workers were not appointed for those at risk. The then Suicide Prevention Coordinator told us that today there are two senior officers, two officers and administration support involved in Suicide Prevention coordination. "Then" he said referring to 2003/4 "they just had me".

One key issue with regard to the care of Ana on May 2nd was whether she should have been identified as being at risk of attempting suicide or serious self-harm. We have considered whether there might have been a different outcome had the ACCT system been in place on that day. As staff had not identified a heightened risk then it would have made no difference if the ACCT system had been in place. It is possible that the previous period of suicide monitoring (the F2052SH from April 17th to 29th 2004) may not have been closed. The ACCT contains a requirement for a further review after the closure. But we were told that even under the F2052SH system, staff on the unit would have known that Ana had recently been thought to be at risk and would have therefore engaged in some closer monitoring. However, this did not lead to anyone on the day considering her to be at heightened risk.

Had Ana been so identified would staff have acted differently if the ACCT system had been in place? The decision to allow Ana to be co-located with another prisoner during the tea time lock up would seem to have been a

sensible decision and one that would have likely to have been taken had she been subject to either F2052SH or ACCT procedures. Similarly the decision to permit her ‘phone calls to her boyfriend following the visit in the afternoon would fit guidelines in both processes. Allowing her out of her cell in the evening to conduct some work fits with much of the guidelines. Additional safeguards that could have been put in place would have been to provide more supervision and to alert her fellow workers to her vulnerability and to advise that she should not work alone. We do not feel that the change in the policy would have made a difference to her management on the day.

Holloway was clearly struggling to provide an effective suicide prevention system during 2004. One key dimension to come out of this investigation relates to the need for staff to be trained to recognise risk factors for suicide and self-harm and to respond accordingly.

We recommend that training in suicide prevention is undertaken by all staff who come into contact with prisoners and that the training is refreshed on a regular basis with managers having responsibility for ensuring continued understanding and compliance with the areas covered.

Part Four: Observations about Inquiry Procedure

Chapter Twenty

Inquiry Procedure

a) Holloway's response to the incident

After Ana had been taken to hospital, the Duty Governor organised a hot debrief for the staff who had been involved in the incident. He told us that he took notes of the debrief but could not remember what happened to those notes. He told us that he had followed the contingency plans for a death in custody. However written statements do not appear to have been prepared by all of the staff involved in the incident. Short notes dated May 3rd were prepared by SO S the Principal Officer, SO P and Sister W but not by others. The internal investigation identified that written notes were not pursued from all staff and recommended that the Governor should remind all management staff responsible for the collation of evidence after any incident of the importance of gaining that evidence as quickly as possible and as practicable after the conclusion of the incident. In addition, the inquiry recommended that these managers be reminded of the need in serious incidents for every individual involved, irrespective of the degree of their involvement, to submit a written account of their actions. It is considered by the internal inquiry that the appointment of a responsible, accountable individual towards the achievement of these goals should be considered as being paramount.

Holloway developed an Action Plan immediately after the incident which sets out actions to be taken, who should take them and by when. The document we have seen looks to have been produced the day after the incident. A number of the 25 actions are described as "ongoing from last incident on 15th April" – presumably the death of another prisoner. Several of the actions listed are recorded as having yet to be completed, including a Critical Incident Debrief which was to "be arranged on completion of investigation" (it is not

clear which investigation) and “a review of the contingency plan for death in custody and serious incident of self-harm – re access, overrides and lifts “. It is not clear whether the action “Check Level of Observation on other wing cleaners who first alerted staff “had been carried out or not.

The plan is organised in an unsatisfactory way and would have benefited from a clearer format distinguishing immediate tasks arising from the incident on May 2nd (e.g. Collation of Core Record, Unit Observation Book, F2052SH and other relevant documents) and other matters which either related to earlier incidents (Review of Use of Bedding – ongoing from last incident) and Training (de-fib and drug awareness).

Moreover we have not seen any later versions of the plan with updates on progress made although we were told that updates were produced.

One of the recommendations in this action plan – “training (defib and drug awareness)” is reported on in updates on action plans which otherwise detail compliance with recommendations made by the Prison Service Inquiry (see below). This is not true of the other recommendations.

Holloway’s current Suicide Prevention and Self-Harm Management Strategy states that “Near misses will be investigated locally by the Safer Custody Coordinator”, defining this as any incident in which the person was resuscitated or taken as an emergency admission to outside hospital. It does not however set out the type of investigation which should be undertaken or the action to be taken as a result.

We recommend that clearer guidance is produced on what kind of immediate internal inquiry should be undertaken following acts of serious self-harm, what evidence should be collated and retained and what form of action planning should be set in place as a result.

b) The Prison Service Inquiry

On June 18th 2004 the Prison Service Area Manager for London commissioned an investigation into the incident by a Prison Governor, who was employed within the London Area Managers Office as the Area investigator. The aim of this investigation was to find out what took place, its causes, the manner in which it was managed and resolved and how a similar occurrence may be prevented or avoided in the future.

The inquiry reported that it was provided with all documentation held by the establishment and requested more from a liaison officer. The list of documentation suggests that not all of this information was in fact obtained.

The Governor in charge of the Inquiry undertook interviews with nine staff and two prisoners and also asked a Healthcare manager at Pentonville Prison to carry out a review of Ana's medical record.

The report of the internal inquiry concentrates on the incident and the events leading up to it in line with its terms of reference. It has relatively little to say about the broader issues in Ana's management during her time at Holloway which may have contributed less directly to the incident on May 2nd.

The report made three recommendations. First that whilst the provision of staff to cover hospital and bed watch escorts will remain an ongoing problem, as many are unplanned and arranged at short notice, the inquiry recommends that the establishment should review its current method of allocating staff to these duties from Residential areas, especially at weekends when staffing levels may already be considerably reduced. It is hoped that an improved system might be identified which would reduce the impact of such escorts on residential area regimes allowing them to function as normal as possible and, above all, at the intended Prisoner/Officer ratio identified in that unit's staffing profile.

The second recommendation was that a coded system for use on the establishment's radio net be introduced to identify an incident's type and seriousness, at the point of asking staff to attend that incident. Once identified

this system was to be introduced immediately, or as soon as possible after all staff had received appropriate training so as to ensure its effective use. The third recommendation related to the preservation of evidence (see Holloway's response to the incident above).

These recommendations have been followed up to some extent. A document dated July 11th 2007 and titled "Extract from Combined DIC and Near Miss Action Plans" explains that as far as bed watches are concerned work was undertaken to investigate the current practices of allocating staff for bed watches and hospital escorts and review procedures if necessary. This revealed that in the current practice used to allocate staff to hospital escorts and bed watches, every effort is made to maintain the staffing levels and regimes on the residential units. At weekends it is recognised that due to the reduced regime in the evenings it is vital that every effort is made to maintain staffing levels and a full regime during the weekend day. The Prison Community Manager reported to the Governing Governor on June 20th 2008 his concern that while this issue may have been taken into consideration with the re-profile, there may not be a clear policy for implementation.

As for the second recommendation about coding of alarm calls, the July 2007 update reports that Emergency coding went live on radio net on February 20th 2005 and is working well.

As for the third recommendation about preserving evidence after an incident, the July 2007 plan records that advice and guidance has already been issued to all Managers, in addition a training plan has been submitted and work is currently under way to review establishment contingency plans in the light of recent recommendations. Furthermore a protocol is to be developed for 'near miss' incidents. It gives a date for review as June 2005. The Prison Community Manager told the Governing Governor in June 2008 that instructions on the preservation of evidence can again be issued as a notice to staff but further work is needed on statements and their coordination.

c) The Independent Investigation

This present investigation was commissioned on May 29th 2009. It has been commissioned by the Secretary of State for Justice under the State's obligation under Article 2 of the European Convention on Human Rights to investigate the circumstances surrounding the life-threatening act of self-harm. While the general level of cooperation with staff at Holloway prison has been good, we have from time to time been frustrated by the slowness of the response to requests for disclosure of documents. We have not had one consistent liaison officer at the prison to deal with our requests.

We have also found the system of disclosure somewhat cumbersome with permission needing to be granted from the Safer Custody and Offender Policy Unit of the National Offender Management Service which is part of the Ministry of Justice.

In addition, although many of the documents requested were supplied following a request from the investigation, there may have been other documents that were in the possession of the Prison Service which would have assisted us, but because they were not requested by us, they were not provided. Some instances of requesting documents later in the Investigation came about as a result of interviews with former Holloway staff who suggested additional items that they felt may be of assistance to us.

We recommend that a dedicated liaison officer be appointed for any Independent Investigation. The person appointed should report directly to the Governor for the duties performed in this role and should be allowed sufficient time away from normal duties to be able to perform to an acceptable standard and to provide the necessary assistance to the investigation. S/he should have the necessary authority to require the assistance of other staff in providing information requested by the investigation.

In addition we recommend that the prison should take a proactive role in providing necessary written information so that, in general, the investigation is in the position of reviewing the documentation and deciding which of that supplied is relevant rather than trying to determine what documents may be available that may be relevant and useful.