



ANNUAL REPORT

HMP/YOI HOLLOWAY

January to June 2016

STATUTORY ROLE OF THE IMB

The Prisons Act 1952 and the Immigration and Asylum Act 1999 require every prison and IRC to be monitored by an Independent Board appointed by the Home Secretary from members of the community in which the prison or centre is situated.

The Board is specifically charged to:

(1) satisfy itself as to the humane and just treatment of those held in custody within its prison and the range and adequacy of the programmes preparing them for release,

2) inform promptly the Secretary of State, or any official to whom s/he has delegated authority as it judges appropriate, any concern it has,

(3) report annually to the Secretary of State on how well the prison has met the standards and requirements placed on it and what impact these have on those in its custody.

To enable the Board to carry out these duties effectively its members have right of access to every prisoner and every part of the prison and also to the prison's records.

The Independent Monitoring Board of HMP/YOI Holloway is committed to being a diverse Board and to carrying out its work in a way that recognises diversity.

Reporting Period

1 January 2016 to 17 June 2016

EXECUTIVE SUMMARY

The decision of the Chancellor of the Exchequer to close HMP/YOI Holloway was announced on 25 November 2015. The announcement came as a complete surprise to everyone associated with the prison and at a time when, as our 2015 report documents, Holloway had greatly improved on many measures. For the last several years IMB monitoring found Holloway to be a safe and decent prison. The IMB's annual report for the period ending 31 December 2015 was published on 14 June 2016. For a fuller picture of the IMB's monitoring of the last year of Holloway and of the closure, this short report should be read in conjunction with the 2015 annual report. Some of the key conclusions of the 2015 report are set out below.

Many of the women in custody in Holloway were vulnerable and had adverse or traumatic life experiences, often including violence and domestic abuse. Many had complex needs including poor physical and mental health and drug and alcohol addiction. The prison's support for vulnerable prisoners was very good, particularly the work of the safer custody team (dealing with self-harm, violence and bullying) and the mental health team. This was also the view of HM Inspectorate of Prisons following an unannounced inspection of Holloway in October 2015. The closure of the prison meant the loss of these effective teams which had been built up over many years and had a depth of experience engaging with challenging and important work.

Over recent years, there were several new initiatives to help the women both in prison and when they were released and Julia Killick who was the governor at the time of closure has to be given much credit for her role in these initiatives. At the time of the announcement of the closure, Holloway had made good progress towards becoming a local resettlement prison. Work and training projects had been successfully set up and more were imminent. The considerable financial investment in this work and the enormous benefits of having good training and consequent employment opportunities for women in London are further grave losses.

Holloway's location in central London, with good public transport links was helpful in its work with other agencies and organisations providing support, rehabilitation, therapies and resettlement assistance. Many of these organisations are London based and local authority funded. Moreover the prison's location made it accessible for families and friends to visit the women. Holloway staff worked hard to help women to maintain contact with their families and a variety of arrangements were in place to encourage and facilitate visits from children. The closure means that there is no longer any prison for women in London. It will be more difficult and expensive for families and children to visit women in prison. This particularly concerning given that many women in custody have children for whom they are the primary carer.

The 2015 annual report set out four questions to the Minister formulated in the light of Holloway's closure. No response has been received yet and this short report will not address any additional questions. The questions related to provision for women prisoners with mental health problems, family contact, resettlement and housing.

This report will focus firstly on the IMB's monitoring of the management of the prison and the experience of prisoners in Holloway from January 2016 until the last women left Holloway on 17 June 2016. It will cover only some of the themes normally addressed in an annual report. It will then go on to report on how the closure of the prison was managed and on the transfer of prisoners and staff to other establishments.

MANAGEMENT OF THE PRISON DURING ITS LAST 6 MONTHS

Following the announcement that Holloway was to close, the prison began the new year with a new Governor and a new Deputy Governor. Their stated priorities at this challenging time were focused on keeping the women safe during the closure process, including maintaining time spent out of cells and in productive activities as much as possible. The first few months after the announcement of the closure were particularly challenging. Tragically, there was a death in custody on 11 January 2016. There is no suggestion that this was in any way linked to the closure process and the inquest has not yet taken place.

The IMB wrote a letter to the Secretary of State for Prisons in February raising concerns including

- a significant increase in the number of women on ACCTs and increases also in acute suicide risk requiring women to be on constant or intermittent watches;
- increased use of 'legal highs', often with dangerous medical and psychiatric consequences;
- increased numbers of prisoners taken to outside hospitals, requiring a number of officers to accompany them, sometimes for several days;
- increased challenging behaviour, including an increased number of assaults on prisoners and staff; and
- an increase in staff sickness absence levels.

While we did not suggest that these issues were directly caused by the closure process, the fact of the impending closure, over a long period, was inevitably unsettling and, we believed, contributed to the risks created by these challenges. Holloway's managers faced added challenges in this unsettled and high-risk period as experienced staff, including residential governors with long experience working with the most complex women, began to move to other establishments. Staff absences began to creep up. Less experienced staff had to fill these roles at a particularly challenging time. Healthcare staff also began to resign, with more use of agency healthcare staff and the associated risks.

The letter was replied to by Parliamentary Under-Secretary of State for Women, Equalities and Family Justice, who did not agree with all of the issues we raised (specifically our observations concerning 'legal highs' and staff sickness absence levels), however, the other points were accepted. The reply emphasised the need to move women with the most complex needs from Holloway first, including those awaiting transfer to hospital under the Mental Health Act. Over the following months, this approach was implemented and the risks we had identified were managed very well.

Health

Having learned that their bid for the healthcare contract had failed at around the same time that the closure was announced, Holloway's healthcare provider, CNWL (Central and Northwest London NHS Foundation Trust) agreed to continue to provide services until the closure was completed. Clinics continued to run right up to the closure of the prison. A good service was delivered and there were very few complaints. Hospital appointments were carefully managed and prisoners remained at Holloway to attend hospital outpatient appointments where necessary. According to the Healthcare manager at Holloway, no receiving prisons reported any medical incidents with women transferred.

Mental Health

The healthcare unit and mental health services were funded by NHS England until the closure. Previous IMB reports have expressed the view that discipline staff and medical professionals worked impressively together in Holloway's mental health services and this continued to be the case throughout the closure period. A number of healthcare staff, including experienced nurses, left to go to new jobs early in the year. This meant an increased reliance on agency nurses, some of whom did not know Holloway well and did not have keys. This was an additional challenge for managers and staff in this area, but was managed without undue impact on patients.

Transfers to secure mental health units were particularly well managed so that women awaiting places were moved directly to hospital and not transferred to other prisons. One woman, who had spent many months located either in the CSRU and Healthcare unit, was eventually transferred to Rampton shortly before Holloway closed.

C1, the mental health inpatient unit was the only dedicated mental health unit in a prison for women led and staffed 24 hours a day by medical professionals. The unit continued to be full and to manage very vulnerable women through the closure period. The Day Centre also continued to operate throughout this period, providing a range of activities for C1 patients and other vulnerable women in a therapeutic, calm and supportive environment.

One of the IMB's main concerns (also raised in our letter to the Minister) was about the mental health provision which would be available to women in other prisons after the closure of Holloway. It is a matter of grave concern that these resources, which have been of such great benefit to the most vulnerable women prisoners over many years are now lost and unlikely to be replicated or replaced at any other women's prisons. Women who clearly need specialist mental health care are not getting it – the very long period to get one woman accepted by Rampton and women who have been carefully looked after in prison are released with no provision in place.

Work and activity

The new Governor maintained a focus on purposeful activity during the closure period. There was some effect on the regime when activities were shut down for more frequent full staff meetings, training days and opportunities for staff to visit other establishments, but this was kept to a minimum. As the population in the prison began to fall, the regime

was adjusted, continuing to provide productive work for the women. For example, there were fewer education classes, the painting party was replaced by a skip party and women became involved in the process of clearing out the landings as they closed.

The London College of Fashion workshop continued to operate in Holloway and then moved to Downview where expansion was planned. Several women working here were hoping to continue to work for the project at Downview.

OMU

As part of the closure process from December there was an effort to ensure all women eligible for HDC were processed and released. However in May the IMB received an application from a woman who was 6 weeks beyond her HDC eligibility date. In response we escalated the issue to the Governor who was surprised to hear that there were outstanding HDC applications and followed up to find there were 8 women past their HDC eligibility dates, all due to delays in getting outside probation reports and escalated the issue to a senior manager in the CRC. It does raise the question of how many women are being held in prison beyond their HDC eligibility with the introduction CRC's.

There were efforts made to ensure that all OASys reports and sentence plans were complete and up to date before women were transferred. However, applications to the IMB revealed that this had not been universally achieved. The IMB was aware of cases where OASys reports and sentence plans were not completed, and others where the woman concerned had not seen or signed the report relating to her. This caused anxiety in the lead up to transfers to other prisons. In this case the failure was not attributable to agencies outside the prison.

RoTL

The number of women released on temporary licence (RoTL) had increased by the time of the announcement of the closure. They were able to continue to go out as before during this period although no new RoTL placements were set up other than for childcare or resettlement

Safer Custody and Listeners

Holloway prison took its safer custody responsibilities very seriously. The Safer Custody team carried out considerable pro-active work to anticipate which women might need help and women's records were perennially scanned for signs of risk.

There was particular concern about maintaining safety and security during the closure. This was highlighted during January and February when there were an unusually high number of incidents including fights between prisoners and assaults on staff and prisoners.

One individual who self harmed prolifically and extremely dangerously was located on C1, the Healthcare unit. Intensive resources were deployed to monitor and manage her safely. She was eventually transferred to hospital at the end of February. During the same period there were bedwatches at outside hospitals requiring the presence of 4 officers. Many officers were cross-deployed and worked extended shifts in extremely challenging

situations. Two officers bravely prevented an escape while escorting a woman to a hospital, and were commended for their actions.

By March the prison became much more settled and there were far fewer incidents, particularly as the population began to fall.

Listeners. The Listeners (run by the Samaritans with whom Holloway has a national contract) also play a key role in supporting women. In addition, there are Samaritans phones on the units which the woman can use any time, free of charge. There are usually 7 or 8 listeners (always coming and going) so that the prison is perennially training more. These listener numbers dwindled as the prison emptied, but there was a concerted effort to keep listeners among the final women left at Holloway.

Safer Custody Team. The Safer Custody team supports the ACCT assessors and looks at reasons for ACCTS, examines observation books, and maintains the self harm statistics. They also support the Listeners Team (along with the Samaritans). Monthly meetings are held where the statistics are examined and a wide range of prison staff are brought together to discuss individual cases.

Staff had to both handle the challenges of a closing prison with the fact that they were being transferred themselves. For the bulk of the time before closure, Both the responsible governor and the Custodial Manager were exemplary professionals throughout. The closure period was an unsettling time for women and, even an emptying prison, the Safer Custody team remained alert to problems and keeping the women safe. There was an unusually high number of open ACCT documents in the first few months of the year, even as the population fell. This was attributed to staff being particularly cautious and alert to keeping women safe following the death in custody and at a time when both prisoners and staff were unsettled, so that ACCTs were opened as a precaution and remained open longer than they might otherwise have done. The number of incidents of self harm was also unusually high. At least some of the dangerous self harming behaviour was attributed to the use of 'spice' or 'legal highs'.

CSRU

The CSRU continued to be busy for much of this period. Unfortunately the governor was responsible for both Safer Custody and the CSRU was transferred to another prison in January, which was further unsettling for the women and for officers working in these teams. The IMB's view was that it was most unfortunate that a manager particularly experienced and respected in dealing with the most vulnerable and challenging prisoners left the prison before that group of prisoners had begun to be transferred.

The IMB continued to monitor Governors' adjudications every week and found them to be well managed and fairly decided on the whole.

THE CLOSURE PROCESS

After the closure of Holloway was announced, the senior management team stopped producing the monthly reports which had provided useful data for monitoring. The IMB did not have a strategic document or regular reports against which to monitor. However, we were kept informed of plans and progress by attending the full staff meetings which

were held fortnightly during this period, and directly by the governor at our own monthly meetings. The initial proposed closure date was August, but the process was completed faster than had been anticipated and the last women left Holloway on 17th June.

The transfer of prisoners

The courts stopped sending women to Holloway at the beginning of March. Because a high proportion of Holloway prisoners were on remand, numbers then began to reduce rapidly. As the population reduced, residential wings were closed one at a time. This meant there were more limited options in locating women around the prison and in separating individuals known to be likely to conflict with each other. This was carefully managed and IMB not aware of any serious incidents resulting.

Women considered to be vulnerable and/or with complex needs were placed on a 'red list' and prison managers actively engaged with counterparts at other women's prisons to arrange for them to be transferred to other establishments at an early stage, before the departure of many of Holloway's experienced officers. This worked well. Prison managers and mental health professionals communicated and worked together effectively to arrange safe transfers. The mental health and therapy team felt that their point of view was respected and that this allowed proper discharge planning and liaising with receiving prisons about individuals' needs. In this respect the relatively slow closure process was seen as helpful. Women who were sentenced and with a release date in June or before, or those with ROTL, mostly remained at Holloway until their release.

Once the population had reduced to around 220 women, a number of prison officers were released to transfer to their new establishments. At this stage the regime was modified, for example, the education timetable was reduced, exercise arrangements were modified and visits slots were reduced.

After an initial period of uncertainty, communication with the women was effective. Managers made good use of the prisoner reps on the landings to distribute information about the process and about the prisons to which they might be moving. A competent and enthusiastic Custodial Manager was assigned the role of managing communications with prisoners around transfers. He set up a Concerns and Suggestions Scheme (CASS) and held weekly meetings with prisoner representatives from each residential unit, keeping everyone up to date with arrangements as they were made and changed throughout the process. He was efficient, responsive and open in sharing information appropriately and also showed sensitivity to individual prisoners' needs. He set up a dedicated applications process for issues relating to the closure and dealt with them very promptly. It was observed that applications to the IMB concerning transfers virtually dried up once this system was established.

The task of ensuring that prisoners were transferred with the amount of property allowed, and not more was addressed. Women were allowed time to sort out their property and encouraged to hand out any excess property before they transferred.

The IMB was aware of a number of women who were very anxious about moving to prisons further away from central London and less accessible by public transport. Many told us that their families and children might not be able to visit them as often or at all. Against, that there were some who were happy with the move.

Transfer of prison staff

Holloway staff were initially very shocked and disappointed by the announcement of the closure, and apprehensive about where they would work. Many had worked entirely or mainly with women. In the event, 66% of staff got their first choice of new establishment and 25 appealed against their transfers of which only 2 were not upheld. Most seemed positive about moving on by the end. From January onwards there was a full staff meeting every two weeks to keep all staff informed about the closure process.

There was some evidence of staff becoming unmotivated during the closure period. IMB members were told repeatedly that a senior Governor has said 'It doesn't matter, Holloway is closing'. Whether or not this was said by that person, we felt that the widespread rumour indicated a level of disenchantment and difficulty remaining motivated. We observed some effect of this on the prisoners. One example which came to our attention a number of times was that women asking for curtains for their showers and windows were incorrectly told that they were not available because the prison was closing. Managers were responsive when issues of this sort were raised by the IMB. Overall, most officers continued to perform well.

CNWL staff

CNWL staff at Holloway felt disrespected and let down by the HR processes of their organisation in the closure process. There was poor communication and little consultation. Most CNWL staff hoped to remain in the NHS and felt insecure and unsupported in this period. By April, most were told where they had been reallocated, but not all had had initial interviews or any opportunity to communicate their needs and preferences. A number of CNWL staff were allocated to new jobs where their considerable skills and experience acquired over often a long period in Holloway would not be well utilised. Some were allocated jobs which they felt were unsuitable. This created risks for individuals of being deskilled, and overall loss of skills for the trust and potentially unsafe working in their new positions. CNWL had no redundancy plan for their Holloway staff. The IMB was aware of a great deal of stress and anger amongst this group of staff resulting from this. However, it is to their credit that they did not allow their own circumstances to affect the services and attention received by the prisoners in their care.

IMB

The IMB had 7 members for most of this period, a much smaller board than in previous years. We were assisted in our duties by a generous secondment of a member from HMP Pentonville. We met every month and maintained our rota applications duties until the last women left the prison. We established good relationship with the new Governor and Deputy Governor, both of whom were open in sharing information and very supportive of our work.

Laura Menachemson 27 July 2016