Findings and Conclusion

Introduction

1. This has been the inquest into the death of Aisha Cleary. The Interested Persons ("IPs") are :

   a. Rianna Cleary represented by Maya Sikand KC and Tom Stoate of counsel,
   b. The Ministry of Justice represented by John-Paul Waite of counsel,
   c. Sodexo Limited represented by Jenni Richards KC,
   d. PCO Lewis Kirby represented by Ian Perkins of Browne Jacobson, Solicitors,
   e. PCO Mark Johnson represented by Charles Bloomer of counsel,
   f. The London Borough of Camden represented by Rachael Gourley of counsel,
   g. Ashford and St. Peter's Hospitals NHS Foundation Trust represented by Sarah Christie-Brown of counsel,
   h. Central and North West London NHS Foundation Trust represented by Robert Goble of Weightmans, Solicitors,
   i. University College London Hospitals NHS Foundation Trust represented by Clementine Robertshaw of Hempsons, Solicitors, and
   j. NHS England represented by Emma Galland of Hill Dickinson, Solicitors.

2. This has been a distressing investigation into the death of a new born baby who, on any view, arrived into the world in the most harrowing of circumstances. Aisha's mother, Rianna Cleary, who was only 18 years of age, was a prisoner in HMP Bronzefield when she delivered Aisha in the early hours of the 27th September 2019. Throughout that time, and at the time of Aisha's delivery and death, Rianna Cleary was alone in her cell and without any clinical or other care and assistance. When prison staff entered her cell later on the morning of the 27th September 2019, Aisha was found to be dead.

3. The purpose of this inquest is laid out in section 5 of the Coroners and Justice Act 2009, which provides that I must ascertain who the Deceased person was and when, where and how she came by her death. Unusually, in this inquest I must also decide whether Aisha Cleary, who was found to be dead following her delivery, was born alive or was stillborn. It should be noted that any reference in this document to Aisha Cleary's "birth" or "death" are used for convenience and are not intended to be indicative of my decision on this important issue.

4. The circumstances of Aisha's birth and death, or stillbirth, raise a number of matters which have required investigation, and it was agreed at a pre-inquest stage that this inquest should comply with the procedural obligations arising under Article 2 of the ECHR, and that the scope of the inquiry should include the following specific issues:

    i. Rianna Cleary's health, and her status in relation to any relevant state agency(ies), when she became pregnant with Aisha,
    ii. The care (including clinical care) offered and/or provided to Rianna Cleary in relation to her pregnancy from February 2019 to the 14th August 2019 by relevant services, including the London Borough of Camden and University College London Hospitals NHS Foundation Trust,
    iii. The care (including clinical care) and support offered and/or provided to Rianna Cleary in relation to her pregnancy, and how the same was managed, following her detention in custody at HMP Bronzefield on the 14th August 2019,
    iv. Information sharing between relevant agencies and services,
    v. The events of the 26th and 27th September 2019,
    vi. Whether Aisha was born alive or was stillborn,
    vii. The date and time at which Aisha died or was still born,
    viii. The medical cause of Aisha's death or stillbirth,
    ix. What Aisha's prospects of survival would or may have been if Rianna Clearly had been offered and/or provided and/or accepted different treatment and care at any time in the course of her pregnancy, labour, or delivery of Aisha, and
    x. Whether a Prevention of Future Deaths Report must be issued.

5. In order to investigate these issues, I have received and admitted oral and written witness evidence, and documentary evidence. Set out below are my findings and conclusion. All my findings have been reached on the balance of probabilities. In this document, I make reference to some of the evidence I have heard but it is not intended to be, and is not, a comprehensive review of all the evidence before me. Rather, my intention is to explain, by reference to parts only of the evidence, why I have reached my findings of fact and conclusion. However, in reaching my findings and conclusion I have taken account of all the evidence I received, both oral, written and documentary. If a piece of evidence is not expressly mentioned, it does not mean that I have not considered and taken full account of it. Unless stated otherwise in my findings below, I found the witnesses from whom I heard oral evidence to be truthful and doing their best to assist me. Therefore, my review of the evidence which is set out below can be taken as my findings as to what probably happened.

A. REVIEW OF EVIDENCE AND FINDINGS OF FACT

Background and Events Prior to the 14th August 2019

6. I first heard evidence from **Sophie Kershaw** who is a Registered Social Worker and the Head of Service for Safeguarding and Quality Assurance for the London Borough of Camden ("Camden"). She gave evidence as to Rianna Cleary's history and her situation from late 2018 onwards. Ms Kershaw herself had only a short and discrete direct involvement in events but, on the basis of her review of the records, she gave evidence to me about Camden's wider contact with Ms Cleary because the two social workers involved (Charlotte McCorkindale and Ruby Price) have both emigrated and were not available to give evidence.

7. Ms Kershaw told me that in 2018, Rianna Cleary was an extremely vulnerable 17 year old. Her childhood had been traumatic as a result of neglect and abuse and she had received services from a number of local authorities over the course of her life. Her education had been disrupted and,

from quite a young age, she had had contact with the criminal justice system. She was also extremely vulnerable to exploitation and harm by others, including county lines (through which children are exploited to assist drug dealers in different parts of the country). Indeed, Ms Kershaw stated that by 2018 Ms Cleary had become immersed in a lifestyle where she was being "*exploited and groomed to be in this sort of criminal world*".

8. It is also important to note that, doubtless as a result of the matters set out above, by 2018 Rianna Cleary was a regular user of cannabis and alcohol and at times there was evidence of self-neglect. Periodically, there were also thoughts of self-harm and suicide. Sophie Kershaw told me that Ms Cleary struggled significantly with her own emotional wellbeing. She said,

   "*We do understand that children that have these complex histories and have been exposed to different levels of harm and abuse, may struggle in managing their own emotional regulation, their own behaviours and seek out different ways of finding their place".*

9. On the 26th September 2018, Rianna Cleary was referred to Camden's Children's Services as being homeless. She had been under the care of Haringey's Children's Services until shortly before this date, but she was referred to Camden because an arrangement for her to live with a family member in Camden had broken down. There were discussions between the two London Boroughs as to which should take on the care of Ms Cleary, but Camden decided to do so. On the 4th December 2018, Ms Cleary was allocated a social worker, Charlotte McCorkindale, who completed a "Child and Family Assessment". Ms McCorkindale met Rianna Cleary a number of times but found engagement difficult. Sophie Kershaw told me,

   "I think there was a recognition that her early life of trauma and … the difficulties that she had managing the emotions, would also make it more difficult for her to engage with some of the professionals. And so it was really important that people were sort of persistent and compassionate in the way that they tried to engage with Miss Cleary."

   Ms McCorkindale also recorded that what Ms Clearly told her was not always fully true, that she found it difficult to be challenged and questioned, and that

she would end a conversation if it became too difficult. On the positive side, she noted that Ms Cleary spoke of wanting to get her life on track, and of getting a job and a stable life; she had recently commented, "*I just want to live in one place"*. But Ms McCorkindale recorded,

"Unfortunately, there's a history of poor engagement, which is understandable given the role modelling she has had regarding engagement with professionals, as many of those who have cared for her have also avoided contact with social care at various times. And therefore Ms Cleary is sceptical of professionals and has a very harsh understanding of the reality of the world."

10. The outcome of the assessment was that Ms Cleary needed accommodation away from her family and Camden arranged for her to be placed in Cecil House which was a Camden commissioned supported living placement for young women between the ages of 16 and 25 years, with 24 hour support staff provided by Centre Point. It was semi-independent accommodation which was provided alongside the services offered under Camden's "Young People's Pathway", which sought to support the development of emotional wellbeing, resilience, and independent living skills, with support for education, substance misuse, and emotional wellbeing. It was intended that Ms Cleary would continue to live at Cecil House beyond her 18th Birthday, and maybe for a number of years. At the time of her placement, Rianna Cleary had been missing, but she was found by the police in a county lines "trap house" in Northampton and, on the 21st January 2019, Ms McCorkindale collected her from police custody and took her to Cecil House.

11. Sophie Kershaw told me that Camden decided that Rianna Cleary would be cared for under section 17 of the Children's Act 1989 ("the Children's Act") as a Child In Need, rather than under Section 20 of the Children's Act as a Looked After Child. This decision was made despite the fact that Ms Cleary had indicated that she wanted to be accommodated under section 20. Ms Kershaw said that, at the time, it was mistakenly thought that the co-operation of the child in question, with matters such as health checks, was a necessary prerequisite for section 20 and that Ms Cleary was not fully co-operative. In a formal letter dated the 22nd January 2019, Ms Cleary was informed that she was not eligible to be a Looked After Child under section 20 because she had not been looked after for a period of 13 weeks since the

age of 14 years. Ms Kershaw accepted that this was wrong and that Rianna had, in fact, been eligible to Looked After Child status. As I shall come to later, the decision was subsequently recognised by Camden to be wrong and was overturned, with section 20 status being granted retrospectively. Unfortunately, as I shall also come to later, it was a decision which had relevant ramifications for the events which followed.

12. Following the placement at Cecil House, there were ongoing concerns as to Ms Cleary's safety and well-being. She continued to go missing intermittently and did not engage with many of the support services which were offered. On the 28th February 2019, she was arrested and taken into police custody where a test showed Ms Cleary to be pregnant. The police informed the Multi Agency Safeguarding Hub ("MASH") and Camden of this and Rianna was referred to ante-natal services. On the 6th March 2019, she was seen at Cecil House by a nurse, Stephanie Crane, who advised that she could be around four or five months' pregnant, based on Ms Cleary's own report of the date of her last menstrual period.

13. Camden arranged a pre-birth social work assessment, which was intended to focus on Ms Cleary's parenting capacity and support needs so that a plan of support could be made. It recorded that Ms Cleary was approximately four to five months' pregnant, with an estimated due date of approximately the 1st August 2019. This was based on Nurse Crane's advice.

14. As a result of concerns for the baby, it was decided that a child protection strategy meeting and investigation under section 47 of the Children's Act was needed, and it was recorded that,

"*When considering the trajectory for this baby, it is sadly most likely to progress to proceedings with a view to the baby being removed at birth unless there is significant change seen across all aspects of Rianna's lifestyle, substance use, presentation; risk of significant harm is too great. With that in mind, this case will progress for pre-birth assessment and consideration of Initial Child Protection Case Conference/pre-proceedings*."

The unborn baby (whom I shall refer to from this point onwards as "Aisha") was allocated a social worker of her own and this was Ruby Price.

15. These developments coincided with the approach of Rianna Cleary's 18th birthday on the 22nd March 2019. As she was being cared for under section 17 of the Children's Act, her case was to be closed on that day, and on the 13th March 2019, Ms Cleary's social worker, Charlotte McCorkindale, met her for the last time. Her record stated,

"*I advised Rianna that the fact that she might be pregnant could affect her housing, and other accommodation may be identified, as babies could not be born in Cecil House. She nodded but didn't want to talk about it, but she did not deny the pregnancy*."

Sophie Kershaw told me that a few days later, on the 18th March 2019, there was a meeting at Camden's offices which Rianna Cleary attended. Ms Cleary was given a letter which informed her that, as her status was under section 17, her case with children's services would close on her 18th birthday, she would no longer have an allocated social worker, and she would now be transitioned to adult services. When Ms Cleary's pregnancy was then mentioned, she promptly left the meeting and she subsequently informed her Key Worker at Cecil House that she had had a miscarriage. It is noteworthy that the formal letter which had been given to Rianna Cleary at the meeting (i) included criticism of her behaviour (for example, in relation to going missing and not engaging with services) even though this was not the reason for, nor relevant to, her case being closed, and (ii) did not set out or explain the further services which were to be provided. Ms Kershaw described the letter's composition as "disappointing" and agreed that it was unnecessarily negative in tone, although she did emphasise that, from the records, she was confident that the fact and the nature of the ongoing support was explained to Ms Cleary.

16. On the 21st March 2019 a professionals' meeting took place to discuss what ongoing support Ms Cleary would need. She was invited to attend but did not do so. It was agreed that (i) ongoing support would be through her Key Worker at Cecil House and the substance misuse services and (ii) Ruby Price would progress Camden's investigation for the protection of Aisha. Ms Kershaw stated that, although Ruby Price was Aisha's social worker, it was also part of her role to identify and co-ordinate the support Rianna may need and that she could, therefore, act as social worker for both mother and baby.

However, when asked about the conflict which could arise, if it were decided that the baby should be removed, Ms Kershaw did accept that Ms Price was not able to advocate for Rianna Cleary. In this regard it is of importance to note that if Rianna Cleary had at this time been recognised as a Looked After Child under section 20 of the Children's Act, as it is accepted she should have been, she would have been entitled to "leaving care services" and these would have included the appointment of a Personal Advisor. Ms Kershaw explained that the Personal Advisor would have been required to undertake a "pathways needs assessment", focused on Rianna Cleary's needs, and then to draw up a Pathways Plan. She said that the support provided is needs led and, in relation to Ms Cleary's pregnancy, the Personal Advisor would have worked alongside Ms Price, but would have been able to liaise with and advocate for Ms Cleary. I have no doubt that the timely appointment of a Personal Advisor could have provided Rianna Cleary with support for what was bound to be a difficult process for her, and that this could have improved the chances of her engaging with the professionals involved, including the clinical services. In fact, however, no Personal Advisor was appointed until there was, subsequently, a legal challenge on behalf of Ms Cleary, as a result of which Camden retrospectively treated her as a section 20 Looked After Child and provided her with leaving care services. As I shall come to below, the Personal Advisor who was eventually appointed did not see or speak to Rianna Cleary prior to Aisha's arrival.

17. So far as the child protection investigation for Aisha was concerned, there was an Initial Child Protection Conference on the 11th April 2019. It was recorded that, by then, Ms Cleary had reported to staff at Cecil House that she had suffered a miscarriage (as stated above). As a result, the investigation was closed.

18. I heard evidence from **Teresa Driver** who was then the Lead Midwife for Safeguarding within the Maternity Department at University College London Hospital ("UCLH") and she told me that her team had been alerted to Ms Cleary's pregnancy by the MASH in early March 2019, because of her vulnerabilities. A "booking appointment", which is the initial midwife review at which all relevant information is gathered and a plan is made, had

been arranged by the hospital's midwifery team for the 22nd March 2019, together with an ultrasound scan appointment for the 26th March 2019. She explained that the scan is needed, ideally in the first trimester, to determine the fact of the pregnancy and the estimated due date ("EDD"); the EDD then determines the planning for the rest of the pregnancy. Teresa Driver told me that Ms Cleary did not attend those appointments, nor further sets of appointments, despite the encouragement of her Key Worker. Ms Driver was concerned and she attended the Child Protection Conference on the 11th April 2019, but she learned that Ms Cleary had reported a miscarriage and consequently UCLH's case was closed.

19. Subsequently, reports were made which suggested that Ms Cleary was, in fact, still pregnant. On the 14th May 2019 staff at Cecil House reported that Ms Cleary appeared to have "a pregnant belly", on the 25th May, Ms Cleary told the police that she was pregnant and this was reported to the MASH, and on the 27th June the Police reported that she was visibly pregnant. Following that last report, Ruby Price was re-appointed as Aisha's social worker and a further section 47 investigation was commenced.

20. On the 4th July 2019, Rianna Cleary was again in police custody when she complained of abdominal pain and was taken to the Emergency Department at UCLH, where a test confirmed her pregnancy. Teresa Driver told me, from the notes, that Ms Cleary told the doctors that she thought she was five to six months' pregnant and that she had had no contact with maternity services, "*As she was concerned social care would be involved and about the possibility of her baby being removed from her care*." Ms Cleary was then seen by a midwife, for a "triage" examination; it was, apparently, too late in the evening for a "booking appointment" or scan to take place. The midwife confirmed the pregnancy, listened to the foetal heart, and estimated that Ms Cleary was 20 weeks' gestation by abdominal palpation. Subsequently, a further booking appointment and scan were arranged for the 20th July 2019, but Ms Cleary did not attend.

21. An Initial Child Protection Conference, which is a multi-agency meeting, was held in relation to Aisha on the 23rd July 2019. It was chaired by **Helen Stack** of Camden who told me that it was unfortunate that Ms Cleary chose not to attend. She agreed that, had Ms Cleary had a Personal Advisor at that stage,

that person would have been in attendance. She said that a key concern at the meeting was the lack of clarity as to Ms Cleary's EDD, and that the view of the professionals present was that a multi-agency plan needed to be made that day, due to that uncertainty and the concerns for Aisha's safety. It was decided that Aisha was at risk of significant harm from neglect and a Child Protection Plan was formally put in place. I was told that, at this stage, no final decision was made as to Aisha's removal, but there was an ongoing prospect of an application to the Court being made, and fostering or adoption was likely. So far as Rianna Cleary was concerned, it was agreed that ongoing efforts would be made to encourage her engagement with maternity services, and Teresa Driver, who attended the meeting, said that was part of the maternity team's role. She said that a further hospital appointment at which Ms Cleary was to be supported by the Looked After Children Nurse was arranged for the 9th August 2019, but Rianna did not attend. There were also unsuccessful attempts to arrange a home visit, at Cecil House.

22. Subsequently, Sophie Kershaw chaired a Care Pathways Panel. She said it was recognised that Ruby Price had tried, repeatedly but unsuccessfully, to engage Ms Cleary, whose ongoing risky behaviours had included drug and alcohol use. It was recorded that,

"*Ms Cleary does not want anything to do with social services and is unwilling to have any conversations with professionals regarding the pregnancy. This makes it difficult to undertake any assessment around her parenting capacity and also suggests that she is currently unwilling to assess her current behaviours and the impact they may have on the unborn baby*".

Ms Kershaw told me that Ms Cleary continued to live at Cecil House and that the plan was to continue to support her to attend antenatal classes and to address her alcohol and drug use, in the hopes that she would change her lifestyle and be able to care for Aisha. It was, however, shortly after this that Rianna Cleary was imprisoned. Thereafter, Ms Kershaw said that Camden held three "Core Group Meetings" to monitor their plan, but the plan was not changed in any significant way as a result of the meetings.

Events at HMP Bronzefield from the 14th August to 25th September 2019

23. On the 14th August 2019, Rianna Cleary was remanded to HMP Bronzefield, which I shall refer to below as "the Prison". I heard evidence about the Prison, and how it operated in 2019, from its Deputy Director, **Victoria Robinson.** She told me that the Prison is operated by Sodexo under contract from the Ministry of Justice and that it accommodates women aged 18 years and over, with a maximum population of 572 prisoners. The prisoners are housed in four Houseblocks and if a prisoner is identified on reception as having a drug or alcohol problem, she is housed on Houseblock 1 ("HB1") where there is a 24 hour nursing presence. In 2019, primary healthcare services in the Prison were provided by nurses employed by Sodexo, and by General Practitioners employed by Cimmaron, and mental health services were provided by Central and North West London NHS Foundation Trust. There is an 18-bed in-patient facility within the Healthcare Unit, but in 2019 it was usual for most of the in-patients to be mentally unwell, many awaiting transfer to a mental health unit. Midwifery services were provided by Ashford and St. Peter's Hospitals NHS Foundation Trust. Routinely, midwives from St. Peter's Hospital attended the Prison on Tuesday and Thursday mornings to hold pre-natal clinics and sonographers attended once a fortnight to undertake scanning; there was an expectation that prisoners would be transferred to hospital for their labour and delivery. Ms Robinson told me that following the closure of HMP Holloway in 2016, the population demographic at the Prison had changed significantly because of the admission of prisoners from London. She said that this accounted for the high level of mentally unwell prisoners in the healthcare inpatient unit. It had also resulted in an increase in the number of pregnant prisoners, but that no commensurate increase in the level of maternity services had been commissioned. The Prison also had a 12-bed Mother and Baby Unit in which babies could stay until the age of 24 months. Also of note is that, by 2019, all Sodexo staff had undergone mandatory "Becoming Trauma Informed" training which, Ms Robinson said, involved seeking to understand why a prisoner was behaving in a certain way and working to empower that prisoner to feel in control of herself and what is going on around her.

24. I heard that following her arrival, Rianna Cleary was assessed by Prison nurses who learned of her pregnancy and her substance misuse issue. **Nurse Jaswant Singh** told me that she was placed on HB1, where the nurse and recovery workers would automatically offer support for drug and alcohol issues, and she was referred to the midwifery team from St. Peter's Hospital for pre-natal support. He said that, routinely, the Prison nursing team would only become involved with a pregnancy related issue if a prisoner asked for specific help and they would not be aware of a prisoner's EDD, for example, unless there was a reason for this to be drawn to their attention.

25. **Dr Sanjeev Sangar** told me that he was working as a locum GP in the Prison and he first saw Ms Cleary on the 15th August 2019, when she was unwell and she was hostile. He treated her and, when he conducted a reception screening the next day, she was feeling better and was happy and smiling, and more communicative. He noted that she was six months' pregnant, and that she had not yet had any ante-natal care, which was something, he said, he had never come across before. Dr Sangar said that he "coded" that she was pregnant on the "SystmOne" medical record system which was used by the Prison, and he made an urgent referral to the St. Peter's Hospital midwifery team. He said this reflected what occurred in the community where, increasingly, ante-natal care was being delegated to the local midwifery services, and the GP had little involvement unless there were some complications. He said that neither he nor any other GP in the Prison saw Ms Cleary again until the 25th September and I shall come back to that below.

26. Teresa Driver, from UCLH, told me that when she learned where Ms Cleary was, she sent an email to the St. Peter's midwifery service to inform them of Ms Cleary's background, including her alcohol use, and that she had not engaged in any ante-natal care. She stated, "*I think she may be expecting in November*". She indicated that the baby was subject to a child protection plan and gave Ruby Price's details. She said that she had intended to, and thought she had, attached to her email the minutes of the Child Protection Conference and also the UCLH midwifery plan, but when challenged she readily accepted that she may not have done so. This meant that St. Peter's did not receive the examination notes of the 4th July 2019.

27. I heard evidence from **Clare Cochrane** who was a Safeguarding Support Midwife at St Peter's Hospital. Her role was to support the Safeguarding Lead Midwife, who was Sarah Legg. She confirmed that the hospital provided midwifery services for the Prison through clinics on Tuesday and Thursday mornings. Ms Cochrane usually attended on Thursday morning only. The level of care was intended to be the equivalent to that in the community and prisoners could be taken to the hospital for care and, if necessary, referral could be made by the midwives to the Consultant Obstetrician, who attended the Prison eight times a year. The Prison GP and healthcare team were contacted and involved, as necessary. So far as medical records were concerned, she said that the midwives kept their own records on the hospital "badgernet" system, but they could also access SystmOne when they were in the Prison.

28. Ms Cochrane told me that she received Teresa Driver's email and noted the safeguarding issues for Rianna Cleary and the baby. She said that she would routinely liaise with social services in these circumstances, but she did not have a point of contact in the Prison for safeguarding issues. She attended the Prison on the 19th August 2019 to conduct a booking appointment with Ms Cleary.

29. **Simmi Dadwal**, the Prison's Mother and Baby Unit ("MBU") Administrator, told me that she met Ms Cleary for first time on the morning of the 19th August. She asked if Ms Cleary would like to apply for the MBU and she said no and she asked Ms Dadwal to leave her cell. Ms Dadwal thought Ms Cleary looked heavily pregnant, and so she told SPCO Brian Rodd, her manager. **SPCO Brian Rodd** was the Senior Officer of the MBU and, he told me, he was operationally responsible for all pregnant women in the Prison whether they were in the MBU or not. He explained that for those women not in the MBU, he would liaise with the midwives and healthcare staff to obtain an EDD and put in place an operational birth plan to manage their needs and to try to ensure a transfer to hospital in good time for delivery. He said that without an EDD, putting an operational birth plan in place was more difficult, but he accepted that, if it was clear that the woman was in the last trimester, then it was possible to do so, and that, in any event, there could never be certainty as to when a baby would arrive.

30. On the afternoon of the 19th August, Ms Dadwal escorted Ms Cleary to her appointment with Clare Cochrane. Rianna answered some of, but not all, the midwife's questions. She told Ms Cochrane that she did not know her last menstrual period, but said that the baby was due in November. She said she had previously had a baby boy, and that she drank six bottles of wine a day or vodka, and smoked cannabis, which Ms Cochrane found to be very concerning. Ms Cochrane examined Rianna and found a good foetal heart beat and movement. On palpation there was a fundal height measurement of 32 cms. Her urine showed traces of glucose and so a glucose tolerance test was required. Ms Cochrane concluded that it was a high risk pregnancy due to the lack of previous antenatal care and cannabis and alcohol misuse. She arranged a scan, to which Ms Cleary agreed, and an appointment with the Consultant Obstetrician, who was due in the Prison on that Thursday.

31. So far as the EDD was concerned, following the consultation, Ms Cochrane emailed Simmi Dadwal to say that Ms Cleary thought she was 27 to 28 weeks' gestation but, "*She palpates at 32 weeks' gestation … So my guess, she is somewhere between the two. This would make her due in October / November*." Despite this, Ms Cochrane recorded in the medical notes an EDD of the 19th November 2019, because, she said, Ms Cleary had said she was due in November, and because it was then the 19th August. She said she had no reliable evidence of the EDD, in advance of the scan result, and she did not agree that, as a broad guideline, the fundal height measurement could be used to estimate the gestation period, with 1cm equating to one week. She accepted, however, that at this initial stage, it would have been safer to err on the side of caution in order to capture the earliest, rather than the latest, potential date for the baby's arrival. I will note here that, as I shall come to later, use of the fundal height measurement as a rough guideline would have indicated that Ms Cleary was about 32 weeks' gestation and that the baby could therefore have been expected to arrive between the 24th September and the 14th October 2019.

32. On the 20th August 2019, Ruby Price emailed the Prison stating,

"I'm aware there is likely not much you can do to prevent this. However I'm extremely worried for the unborn baby's safety should Miss Cleary be released back into the community. There is currently a child protection plan but Miss Cleary has not been engaging with that. I've attached the minutes of the most recent plan to highlight. Can you help me by providing the process for bail applications, so I am aware what is involved?..."

Carleigh Marshall told me that she was the Prison's Offender Supervisor and her primary responsibility was for assessing and case managing sentenced prisoners. She said she had contacted Ruby Price and become "caught up" in being the point of contact for Camden, whereas that should have been the family support worker, Caroline Dixon. She said it was not her job to support pregnant prisoners and she had not been trained in safeguarding of children or babies. She considered that she subsequently received important information from Ruby Price which she did forward to Caroline Dixon and Brian Rodd, by email and orally, but the information was not collated or stored in a way it should have been.

33. Later on the 20th August, Ruby Price attended the prison to visit Ms Cleary. Ms Marshall arranged for SPCO Rodd and Simi Dadwal to be present also. Ms Price wrote a full note of the meeting in which she stated that she reminded Ms Cleary that she was the baby's social worker, but told her that a Personal Adviser was going to be allocated to Rianna herself as she had now been granted care leaver status, and that "*Rianna became really happy at this and cheered*". Ms Price went on to talk about the baby, but Ms Cleary resisted this saying that "*she is just one person*" and that *"until the baby arrives there is no baby to speak about."* Ms Price recorded that she gave a letter to Rianna Cleary which stated,

"I'm writing to you on behalf of Camden Children's Services because Camden is extremely worried about the well-being of your unborn child and its safety and the risk to your child in the community in the care of you when you are released from prison. Our concerns are that the baby is at risk of being exposed to drugs and alcohol

in the environment as you are involved with dangerous adults and you have a criminal history.
From the history we've gathered, you are at risk of eviction from Cecil House if you intend to return there after your prison term. Professionals have tried engaging with you, but you have resisted any assistance. Your baby will be at risk of significant harm due to your chaotic and unstable lifestyle and behaviour and neglect in not seeking antenatal care. We believe you're around 20 weeks pregnant and there is no information about the development of the baby.
I'm therefore writing to let you know that we will be going to court once your baby is born to try to ensure your child is safe. This could mean that your child will be removed from your care. And what you must do now, first of all, get a solicitor. It's really important you get advice from a solicitor who specialises in family law and to get your wider family involved…."

Ms Price recorded that, in response, Ms Cleary said something like, *"Do what you want to do."*. Ms Price noted that, "*She says she wants to care for the child. She said she doesn't want to talk about it until it's born. Social worker explained that this wasn't an option because it will be too late and will mean Rianna will not have a choice what happens if it gets to that stage*."

When asked about this meeting and the letter, Sophie Kershaw stated that the reference to 20 weeks' gestation was obviously a significant underestimate on the basis of what Camden had previously been told. She agreed that Ruby Price was in a difficult position and faced a degree of conflict in that her primary role was to look out for the safety of the baby.

34. SPCO Rodd said that Ruby Price had been clear, direct and honest with Ms Cleary about the approach Social Services were to take, but he said that Rianna Cleary was "*obviously very upset, and understandably so*." He said he had not made a note on NOMIS [the Prison's electronic record which could be seen by all staff] and he should have done so because these were obviously matters which would have an impact on Ms Cleary and about which operational staff, especially the staff on HB1, needed to know. He did not pass any of the information from the meeting on to the healthcare team either, but he expected they would be informed by the midwives. As far as Ms Cleary's EDD was concerned, SPCO Rodd accepted that on the 21st August he was copied into a chain of emails in which it was suggested by a

community nurse that Rianna Cleary could be "*seven months pregnant, maybe more*". He said he would have discussed this with Clare Cochrane. He said, "*We certainly discussed September as a possible time, a possible EDD. But from my point of view, clinically, handing her that information was about her trying to get a firm date for us*".

35. Ruby Price provided an account of the meeting of the 20th August to Clare Cochrane who told me that it presented a very concerning picture and that it had looked as though a multi-disciplinary team approach was going to be needed. She said she expected this would be triggered following the appointment with the consultant.

36. On the 22nd August 2019, **Dr Karin Leslie** attended the prison and saw Rianna Cleary, together with Clare Cochrane. Dr Leslie told me that she is a Consultant in Obstetrics and Maternal Foetal Medicine. She had started as the Lead for Maternal Medicine at St. Peter's Hospital in June 2019 and this role also gave her responsibility for the governance of the clinical services being provided to the Prison. Additionally, she was required to attend the Prison to hold eight ante-natal clinics a year. She said she had had little hand-over and no induction meetings with anyone at the Prison, and she did not have a point of contact at the Prison. She said that almost all the pregnant women in the Prison needed additional care and were high risk, and the fact that they were in custody presented a barrier to providing care which further raised the risks. Dr Leslie said that as she had only eight clinics a year, it meant that she had a lot to do for her patients in a short amount of time. She agreed, though, that it was her responsibility to ensure that the prisoners, who were her patients, received the medical care they needed, however long that took, and that would include ensuring there was in place an effective plan for their maternity care. Dr Leslie also accepted that, if it were the case that the level of maternity services being supplied to the Prison was insufficient to meet the needs of the prisoners, it was her responsibility as the service lead (together with others) to address that issue.

37. Dr Leslie said that when she saw Ms Cleary on the 22nd August she knew that she was a high risk teenage pregnancy, that there were issues with alcohol use, and that Rianna had been in the care of social services but, she said, she did not know that the baby was the subject of a child protection plan and was

at risk of removal. She said that when Ms Cleary came in and she introduced herself, there was no eye contact and , she said, "*it felt like things were quite rapidly shutting down*". She found her hostile to questioning. Clare Cochrane said her presentation was quite different to their first meeting. She said that Dr Leslie explained the need for a scan and Ms Cleary did not refuse, but when the Doctor discussed the dangers of alcohol use in pregnancy, Ms Cleary said she wanted to leave. Ms Cochrane persuaded her to stay, and told her that she needed an "anti-D" injection because of her blood type, and a glucose tolerance test, but she refused these. She allowed Ms Cochrane to listen to Aisha's heartbeat, but Ms Cleary then left.

38. Dr Leslie said that her plan was to arrange a sonographer's ultrasound scan, followed by a doctor's foetal medicine ultrasound scan, to help establish an EDD and to check for placenta site and any structural abnormalities. She believed Ms Cleary had agreed to these scans. She said that her expectation was that she would have further information from the scans and then, either she, or another foetal medicine colleague, would see Ms Cleary in person for another clinical consultation two weeks later. In relation to the 32 cm fundal height measurement, Dr Leslie said, "*It's a piece of relevant clinical information. So it certainly tells you that somebody is in advanced pregnancy. It tells you that they're not in the first or second trimester. … It would give you a very wide window of what stage of pregnancy you might be at. So it's not meaningless. It's a useful single piece of information. But can you date a pregnancy with it? No.*"

Dr Leslie said that she did want the GP and Prison healthcare team to know about the consultation, but assumed a summary was being placed by the midwife on SystmOne. She was asked whether, in view of Ms Cleary's risks, including the risk of prematurity, she had considered writing to the GP and making a plan for the healthcare team to follow. She said, "*So my understanding is that women who are in Bronzefield in an advanced state of pregnancy that there should be an understanding by the teams that they're looking after a cohort of women that have an increased risk of pre-term birth. So certainly at that stage, with the knowledge I had available to me of how the system worked, I wouldn't have thought to make an individual letter or a plan to the GP or the healthcare team to say birth is imminent and this is what you need to watch for and plan for.*" Dr Leslie said, though, that if she had known about the threat of the baby's removal, that may have led to more team work to support Rianna's

needs, including managing the emotional and psychological impact of the pregnancy and birth. Dr Leslie told me that she did not see Rianna Cleary again, but she was later told that she had refused to attend for scanning and was declining midwifery services. I shall come back to the doctor's response to that, below.

39. At this point, I will note the evidence of Dr Sangar, the GP, who said that Ms Cochrane's short note of the consultation, which she had placed on SystmOne, was not drawn to his or his colleagues' attention and he was not aware of the Consultant's involvement at the time or subsequently. He said, "*I would have assumed that, if there were problems with her antenatal care or engagement, that someone may have flagged that up*".

40. On the 29th August 2019, Ruby Price visited Rianna Cleary for a second time. SPCO Rodd was present for part of the meeting. There was discussion about Ms Cleary's desire to apply for bail and Ms Price informed her that Camden would not support an application because it was thought that her behaviour in the community would put the baby at risk. Ms Cleary was asked whether she would seek help if she was in labour and she swore and insisted that she would. Clare Cochrane also joined; she wanted to encourage Rianna to attend for scanning as she had failed to attend appointments on the 27th and 29th August. It was recorded by Ruby Price that "*Rianna refused to budge. Brian asked Rianna what will happen if she doesn't get the option to keep her baby after it's born, and Rianna said that, 'You will watch me go crazy*'." SPCO Rodd recalled Ms Cleary being upset and angry in the meeting.

41. On the 3rd September 2019, Clare Cochrane went to the Prison especially to see Rianna Cleary. She was concerned that she had not attended for scanning and wanted to try to re-establish their earlier level of communication and talk to her about the anti-D injection she needed. SPCO Rodd told me he collected Rianna for the appointment and spoke to her for an hour to persuade her to attend. Ms Cochrane said that when they reached her, Ms Cleary was agitated and suspicious. Once they started talking, and she explained about the injection, Ms Cleary became very abusive and, when she asked her to stop swearing, she walked out, saying she did not care about what effect not having the injection could have on the baby or future pregnancies. Later that morning, Ms Cochrane went with SPCO Rodd to Ms Cleary's cell to try again

to talk to her, but she turned up the volume on the television and so it was impossible. SPCO Rodd said that after these events, he found that Ms Cleary would not always speak to him.

42. Ms Cochrane said she updated Dr Leslie and made another midwife appointment for Ms Cleary for the 5th September. She said that she also escalated the matter to her manager, Sarah Legg, and asked her to try to engage with Rianna. **Sarah Legg** said that she was the Named Midwife for Safeguarding for Ashford and St Peter's Hospitals NHS Foundation Trust and was responsible for overseeing the safeguarding of pregnant women with complex social vulnerabilities. She said she was aware that Ms Cleary had disengaged from care on the 3rd September and she attended the Prison to meet Rianna to try to engage her and bring "fresh eyes". She said she had skills and experience with complex women. She was asked what approach should be taken with a vulnerable prisoner who was becoming hostile, and she said,

"… there would always be a reason for why the person is presenting as such. It is very important to validate their feelings, to resonate with them, and to potentially name those feelings, to allow for a period of, to de-escalate really and to allow calm, you know, calmness, time and space, and then possibly to say, you know, "I am going to leave you for some time. I would still like to talk to you," and then try and revisit. And obviously ensuring that the environment that you are using is such where you can try and make that person feel safe and feel valued and listened to."

Ms Legg said she wanted to meet Ms Cleary between 12.00 and 12.30 but she was in the Education Department and so she and Ms Cochrane went to see her there. They did not alert Ms Cleary or anyone in the Prison and so Rianna was not expecting them. Ms Legg said Ms Cleary was standing in a very crowded room with other residents in quite close proximity. She said that Clare Cochrane held back but she approached Rianna, introduced herself as part of the midwifery team, and asked if they could speak. Ms Cleary said no. So then she said, "*Could I have 60 seconds of your time*?" and Ms Cleary said, "*Step away now*." Ms Legg said she became quite heightened and angry and then she said, "*Step away now otherwise I won't be responsible for what I do*," or words to that effect." Ms Legg told me that she then said, "*Rianna, do you care*

about your baby?" Ms Cleary did not answer but was, she said, "*presenting as anxious*" and so Ms Legg said to Clare Cochrane, "*I think we should leave now*," and they left. Ms Legg said that she felt threatened by what had been said. The encounter lasted no more than three minutes.

43. Given what she had explained about the approach which ought to be taken when seeking a fresh start with a disengaging vulnerable teenager, she was asked about the appropriateness of this encounter and she accepted that it had been inappropriate. When asked why she had asked Rianna Cleary whether she cared about her baby, she said she was trying quickly to establish a rapport. She accepted that it appeared to be a judgmental question, but said that she had felt frustrated and upset because she had gone to the Prison with a high expectation that she would achieve a 360 degree change in Ms Cleary, but she had not received any engagement back from her. I asked the witness whether the question had, in reality, been a "bite back" following what she found to be threatening behaviour by Ms Cleary; Ms Legg denied this, but I find that this probably was the case. In any event, I find the way in which Ms Legg had approached and managed her encounter with Rianna Cleary was not only contrary to the approach which she herself had recognised was needed, but was also wholly inappropriate and unprofessional in all the circumstances. She had been asked by a junior colleague to use her skills and experience to assist with the midwifery team's unusually difficult and fragile relationship with a very vulnerable patient, but her approach had very probably made matters worse.

44. Ms Legg told me that after they left, "*I said to Clare that we need to contact the unborn baby's social worker and to consider police protection when the baby was born, because I was concerned about Rianna as she appeared to be so volatile. Clare then sent an email to the prison saying our visit had not gone well and that Rianna had not engaged with us. Clare related to the prison my concerns about Rianna and the need for police protection upon birth to be considered. I also asked for the social worker update, to update us on what the local authority's plan was once the baby was born.*" The witness said that by "police protection", she had meant a Police Protection Order, although it was put to her by Ms Gourley, on behalf of Camden, that this was not something which Camden would have sought.

45. Ms Legg agreed that, following this encounter, there was an obvious need to put in place a plan to address how Ms Cleary's condition was to be monitored if she continued to refuse to engage, so that the start of her labour would be identified and all necessary support could be given. She accepted that this was her responsibility. She also agreed, however, that in the three weeks between the 5th and the 26th September, she did not take any steps towards putting in place such a plan. She said that ordinarily there would have been a multi-disciplinary team meeting between the hospital and the Prison and that this would have been useful and prudent in relation to Rianna Cleary's care. Indeed, she accepted that there was an obvious need for such a meeting but she said she could not recall why one had not been arranged. She accepted that she had not given any directions to Ms Cochrane to arrange an MDT with the Prison and could not explain why she had not done so.

46. Clare Cochrane told me that, at this stage, she considered that there had been a complete rejection by Rianna Cleary of the ante-natal care services and so she sent out a safeguarding alert to colleagues at the hospital, and to Ruby Price and SPCO Rodd, saying that Ms Cleary's current attitude was that she did not want any care. She also updated Dr Leslie, and sent an email to the Prison's healthcare team alerting them to Ms Cleary's "high risk pregnancy" and stating,

"EDD unknown but Rianna states it is in November 2019. Rianna is currently refusing all maternity care. Rianna has not had an ultrasound this pregnancy, so due date for unborn is unknown. Rianna has O negative blood group. She has refused anti-D in line with NICE guidelines. Should Rianna state that she is bleeding, and this is confirmed or looks as if she is in labour, Rianna must be transferred to hospital immediately for care as there are concerns for the well-being of this unborn."

Ms Cochrane accepted that (i) she had not given any guidance to prison operational staff or nurses (who were not midwives) as to what the early signs of labour may look like and (ii) she had not used this opportunity to seek to make a joint plan with the Prison healthcare team as to how precisely Ms Cleary was to be managed between that time and the birth. She also accepted that, on the basis of what was known, including the previous 32cm

fundal height measurement, she ought to have made it clear that the baby could arrive at any time.

47. I was told by **Mercy Mangwiro**, who is a Registered Nurse and was the Deputy Head of Healthcare for the Prison at the time, that on 6th September 2019 Ms Cleary was placed on the Prison's Complex Case Ledger to ensure she received daily interaction and monitoring by healthcare staff, as she was not engaging with her maternity appointments. She said that the precise nature of the checks would depend on the individual area of concern. She said the records showed that between the 6th September and the 27th September, Ms Cleary was seen by clinical staff on some, but not all, days.

48. On the 10th September 2019, Ruby Price attended the prison for a third time but Miss Cleary refused to see her. Sophie Kershaw accepted that, by this time, it was apparent to Camden that Aisha could arrive imminently, but when I pressed her to explain what steps Camden were taking, in discussion with the Prison, to ensure a plan for the safety of mother and baby was in place, she was unable to identify any. She said that on the 16th September the third "core group meeting" was held by Camden. It is apparent that, by this stage, there was clear consideration not only of removal of the baby at birth, but of adoption as well, and on the 17th September an "Initial Permanency Planning Meeting" was held and the likelihood of the need for adoption was noted. Ms Kershaw acknowledged that, at about this time, Camden also sought clinical advice as to how best to support Ms Cleary through this process. The importance of the Personal Advisor in supporting her was recognised, as was the fact that it would take time for a relationship of trust with the Personal Advisor to develop. Ms Kershaw accepted that the opportunity for this to be in place before Aisha's birth had been lost because a Personal Advisor had not been appointed until the 4th September 2019, and had not even spoken to Ms Cleary prior to Aisha's arrival. There was a recognition by Camden that, overall, Rianna Cleary had been let down by social services in relation to the delay in her Looked After Child status being granted and her post-care services being provided.

49. As I stated earlier, Dr Leslie did not see Ms Cleary again, but she was told that she had refused to attend for scanning and was declining midwifery

services. She was asked, as the Consultant responsible for Ms Cleary's care, what the plan had then been. She said, "*My understanding was that a plan had been put in place to make sure that the team within Bronzefield were aware that she was high risk, that she was in a state of advanced pregnancy and that she wasn't engaged. And that as a team they were exploring different ways to support her and to try and engage*". When pressed as to what she thought the Prison's plan involved, she said her understanding was that "… *there were ongoing attempts to engage with her and to change approaches and to try different ways of engaging, including regular offers of care. My understanding was that there were other services within the prison that were available. So group session, antenatal classes and that staff were trying to support access to them*". She said this understanding came from "*corridor conversations*" in the hospital. She said that we would say, "*What else can we do? What could we try? I can't think of anything else."* She said she asked the midwives, *"You've got experience of working in the prison. Is there anything else you can think of*?" and ,"*Talking to Sarah [Legg] who had also had experience of working in that setting, asking "Is there anything else you can think of?" There wasn't*."

50. Dr Leslie accepted that none of these discussions was recorded and that she did not take any steps to put in place a plan to avoid the recognised risk of Ms Cleary giving birth alone in her cell. Further, she said that on the 12th September 2019, she received an email from the Lead Sonographer for the Maternity Service informing her that Ms Cleary had not been scanned at the Prison that day and that a scan had been re-booked for the 26th September. The sonographer asked Dr Leslie, "*Should the matter be brought forward and an attempt made to bring her to hospital for scan and consultation*?" Dr Leslie said she replied, "*Rianna has, despite a number of offers, declined all scans. Did she actually accept today? She has capacity and has seen Clare and myself. I think it is better to await further information from the Midwives and the Healthcare Team at Bronzefield rather than arranging a visit to the hospital*". She said the information which was awaited was "*whether she [Ms Cleary] would accept our review in hospital and a review again with me*". She did not recall hearing anything further but assumed Ms Cleary had subsequently been asked and had refused further care. Dr Leslie agreed that by the 12th September the situation was urgent, but she thought that "*there were emails and meetings that were held with various people, by Sarah [Legg] and Clare [Cochrane] within Bronzefield, to try and engage,*

and then also to work together with the Healthcare Team within Bronzefield to put a plan in place".

51. On the 19th September 2019, the concerns about Ms Cleary's non-engagement were discussed at the Prison's Maternity Services Liaison Committee meeting. This was a recently established committee involving the Prison staff and Birth Companions (a charity working in the Prison) which met quarterly to share information and address improvements in perinatal services. Rachel Flatters, a midwife from the hospital was present. At the end of the meeting, it was noted that SPCO Rodd would make a referral to **Christy Pitfield** of the Mental Health In-Reach Service. He told me that he did not remember being given that task and that Ms Pitfield was herself present at the meeting, but Ms Pitfield said that, as no referral was received, she did not take any further action. In any event, the mental health services did not become involved. Dr Leslie told me that, at the time, that she was not aware of these meetings, nor of the discussion concerning Ms Cleary.

52. I have already mentioned **Caroline Dixon**. She gave evidence and told me that her role was family support and, earlier in 2019, she had also become the Care Leavers Lead for the Prison. She said that when a care leaver arrives in custody she would put an alert on the system and make contact with the Local Authority to establish whether there was a Personal Advisor and, if so, to ensure they knew how to visit the prisoner and fulfil their support responsibilities. She said that a care leaver ought to have in place a "Pathway Plan" and that, ideally, she would like to see it because it may highlight needs of which the Prison was not aware. She said once it was established that a prisoner was a care leaver, it was for her, and not the Offender Management Team, to liaise with the Local Authority. Ms Dixon said that she was required to hold an initial meeting with the prisoner to introduce herself and establish the prisoner knew her legal rights. Rianna Cleary had been brought to her attention on the 16th August 2019 by Carleigh Marshall and she had been copied in to some of the email exchanges with Ruby Price which followed. She accepted that it was her responsibility to liaise with Camden in relation to Ms Cleary's care leaver status and it was the responsibility of the senior officer on the MBU to liaise with Camden concerning the baby's child protection plan.

53. Ms Dixon had not kept written records and her memory was vague, but she recalled learning at some point that Ms Cleary did not have a Personal Adviser. An initial meeting with Ms Cleary was arranged for 30th August, but she did not attend, and no meeting in fact took place until 20th September 2019, when she recorded,

"Ms Cleary is coming across as she is detaching from her unborn child. She stated that baby is going to be taken away and so what's the point? I believe Ms Cleary is very scared about the pregnancy and birth and is completely lost and doesn't know what to do. Also, there is an element of stubbornness. I feel that Ms Cleary has her own plan for when baby wishes to arrive. This could be giving birth alone as she doesn't want anyone to take the baby away."

Ms Dixon said that she was aware that, by this time, a Personal Advisor had been appointed by Camden and she planned to meet them to ensure the Pathway Plan was completed by Camden. In the meantime, on the 23rd September, she completed a plan for how the Prison would support Rianna Cleary. This included the following,

"*Ms Cleary informed that she is very scared about her pregnancy and birth. States the baby will be taken away at birth, so what's the point of anything? All staff to provide support to Ms Cleary so that she doesn't feel alone and can turn to a significant person if needed".*

Ms Dixon was asked how the direction was to be disseminated and said that she shared it with her line manager and with Carleigh Marshall, SPCO Rodd, and Ms Cleary's appointed keyworker, PCO Ashley Jenkins-Lind, and she intended to have a meeting to identify a member of staff on Ms Cleary's houseblock, to whom she was willing to talk, as a "significant person". She said, though, that the intended meeting never took place and she could not now explain why not, and that she had not taken any steps to alert staff of the need to support Ms Cleary.

54. SPCO Rodd told me that he read Caroline Dixon's email, but he was, of course, already aware of Ms Cleary's refusal of maternity care, which he described as "*unprecedented*". He said he had been trying to involve others,

such as Nurse Zenal Unal, in persuading Ms Cleary and, on the 24th September 2019, he sent an email to his manager reviewing the situation. He said,

"I have been to see Ms Cleary again this morning and she is still refusing to engage so I have spoken to Raff and Tracey on House Block 1. I told them that as Ms Cleary has not engaged, her risk of giving birth in-cell increases by the week and that we need to make the nurses aware of this. I will also bring this up in the morning meeting tomorrow. I will then put together a birth plan in conjunction with the Local Authority and make sure that we have our bases covered in respect of planning for outcomes. I will also speak to Sarah Legg as she is the Safeguarding Midwife Manager at St. Peter's and parallel plan with her so that this is joined-up. If Ms Cleary does get bail we will need to collect as much information from her as we can about her whereabouts as there is a high possibility she will give birth on her own".

The reference to Raff and Tracey were to the manager of HB1 and to SPCO Tracey Todd who was based there. He said it was not his role to give directions to them as to how to manage or monitor Ms Cleary, but he thought that as a result they would make the operational staff on HB1 aware of Rianna Cleary's risk of an in-cell birth and that they would keep an eye out for her.

55. I heard evidence from **Sally King** who said she was the manager responsible for the operational side of the Healthcare Unit. She learned about Rianna Cleary for the first time on the 24th September when, she said, she happened to overhear SPCO Rodd discussing her. She said there was a weekly multidisciplinary care planning meeting held in Healthcare at which concerns about any prisoner could be raised and she asked him to attend the next day so that Ms Cleary could be discussed. Ms King said she discovered that SPCO Tracey Todd had a rapport with Ms Cleary and she asked her to attend also. She said that at the meeting on the 25th September, SPCO Todd was tasked to encourage Ms Cleary to attend for her scan appointment, now fixed for the 26th September, and Ms King decided that, if she did not co-operate and attend, then she should be relocated to the inpatient section of the Healthcare Unit. She described this as a placement of last resort because its appropriateness for a heavily pregnant woman was "questionable" given the incidence of mental health patients and the "noise, smell, and lack of hygiene". She said that, although she knew that Ms Cleary would not be forced to go to healthcare against her will, she did not make an alternative

plan at the time. SPCO Brian Rodd told me that he thought the plan was probably unrealistic as Ms Cleary would not agree to the transfer, but, he said, it was difficult to think of a "plan B". Ms King said that on the 26th September she raised Ms Cleary in the morning managers' operational meeting and handed the situation over to the Duty Manager, Mark Hodges, before she went off duty.

56. Dr Sangar, the Prison GP, told me that, as it happened, he had been asked to see Ms Cleary on the 25th September and he had done so. She had been referred for hand tremors. He examined her and found it was a tremor of unknown cause, and planned to do blood tests and then review. He said he did not discuss her pregnancy because he was unaware that she had been refusing ante-natal management. He said he appreciated there were some notes on SystmOne, but these were not easy to spot and the midwifery team had not alerted him. He said that with, what he had since learned was, "*such an alarming level of lack of acceptance of antenatal care, one would probably want to discuss this with the larger primary Healthcare Team to see if there may be some other strategies one could deploy to try and persuade the patient to engage*". Had he been asked, he said, he would have been only too ready to try and assist, because he felt he had some rapport with her. He did not know whether he would have succeeded, but he said, "*I think I am the only General Practitioner that had seen Ms Cleary on three separate occasions, and I think sometimes just having a discussion and spending time talking to the patient can potentially reveal a number of barriers that they may have in terms of accepting care. I think the great purpose of sort of having Multi-disciplinary Team Meetings is to be able to share and strategize as to how you can better care for a patient, or sometimes perhaps just agree that all efforts are being made*." He said that most of the prisoners had complex needs and that the care he was able to provide fell short of what one would expect in the community for a number of reasons, one of which was the lack of a joint approach by the different teams, and he could not recall ever being invited to a multi-disciplinary meeting about a patient.

57. On the afternoon of the 25th September 2019, there was a further significant event. **Itayi Chigovanyika** told me that he is a Registered Nurse and that at about 14.00 hours on the 25th September he had been walking through the

main courtyard of the Prison, on his way to HB1, when Ms Cleary approached him. She told him that a prison teacher had said her baby will be taken away after she gives birth and if that happens she will kill herself or kill someone. He said that Ms Cleary was upset and angry, but he told her that he had to cut her short because he was rushing to conduct a clinic on HB1, and he "*…advised her on how to access support within the establishment in the event of her finding it difficult to cope with the current situation.*" He said that SPCO Todd was standing about five metres away but did not join in the exchange. At 18:17 hours that day he made a note in SystmOne stating,

"Attended to see Ms Cleary after it was reported that she was tearful. She stated that she was informed by SPCO and education worker that her baby will be taken away from her after she gives birth. She stated that if it happens as they are saying, she will kill herself. She stated that she doesn't have anyone outside to look after her baby. Her mother is an addict, and her father is in prison, she is the only child. Currently, she states she is frustrated if they take her child away from her. She states if it happens, it's either she will kill herself or kill someone. Currently no thoughts of harm to self, or the baby. She stated that it will hurt herself if they do take child away. Poor eye contact, aggressive demeanour but cooperative despite state."

The witness was asked whether he considered opening an ACCT [Assessment, Care in Custody and Teamwork], which is a process through which a prisoner at risk of self-harm can be risk assessed, observed and supported, and monitored. He said he assumed that Ms Cleary was already on an ACCT because of her non-engagement with medical input and, at one point, the witness had suggested that he thought he had seen SPCO Todd holding an orange ACCT book. He was asked why, if he thought an ACCT was open, he had not made an entry in it in order to record his exchange with Ms Cleary, a step which he accepted would obviously have been necessary. He said that at about 16.30 hours that afternoon, whilst he was still on HB1, he had gone to the hub to find SPCO Todd. He said he told the officer what Ms Cleary had said about harming herself and that he advised her to review the level of observations and monitoring. He said he did not mention an ACCT book at the time, but said he assumed that the officer would then make an appropriate entry in the ACCT book. He was asked what the officer's response had been and he said he could not recall at all.

58. I heard evidence from **SPCO Tracey Todd** who said that she was a senior officer on HB1. She knew Ms Cleary from when she first arrived and she thought all the staff on HB1 knew that she was pregnant and was not engaging with the midwives. She said she was visibly pregnant but they did not know when the baby was due. She said, "*Generally, we kept trying to get Miss Cleary to engage, we never pushed her too far with it and were always minded of being very careful with her*". She found that Ms Cleary was willing to talk to her and agreed that on the 25th September she had been asked to encourage her to attend a scan booked for the following day. She was asked about the encounter that afternoon described by Nurse Chigovanyika. PSCO Todd said she could not really remember this incident. She said she did recall Ms Cleary being upset in the main courtyard, about something a teacher had said, but she thought that was the following day. She did not recall Ms Cleary speaking of self-harm and she did not recall being told of it by anyone else.

59. When questioned by me, Nurse Chigovanyika accepted that, despite Ms Cleary making a serious disclosure to him and raising the risk of self-harm and suicide, even on his own account he had not seen fit to confirm whether or not an ACCT was open, nor, if open, that SPCO Todd would make an appropriate entry in it. I do not, however, accept his account. His note on SystmOne makes no mention of an open ACCT, nor of advising SPCO Todd to review the level of observations and monitoring. I find that the nurse did not assume or believe that an ACCT was open; rather, he either failed to consider opening one or, having considered it, he decided not to do so. Further, I am not satisfied that he asked SPCO Todd to review Ms Cleary's level of observations. It is clear to me that an ACCT ought to have been opened by Nurse Chigovanyika, and the failure to do so was a significant lost opportunity to put in place monitoring of Rianna Cleary which, as the nurse himself correctly recognised, she needed.

60. Ms Cleary's threats of self-harm were also brought to the attention of an officer on HB1 on the afternoon of the 25th September. **PCO Richard Vaney** told me that another prisoner informed him that Ms Cleary was wanting to self-harm (and I received evidence, which was read, from two prisoners

which indicated that Ms Cleary was upset and crying, and threatening to throw herself down the staircase, because she did not want her baby to be taken away). PCO Vaney said that he spoke to Rianna in the office and discussed opening an ACCT. He said she was adamant that she did not want that, and she said that there was no problem at the moment, but she may self-harm if her baby is taken away. He said that he decided not to open an ACCT because he saw the risk as being a future risk, following the birth. He thought she was then about seven months' pregnant or so. He said he made a handwritten entry in the B spur observation book, stating,

"*Miss Cleary has said that if the baby is taken from her when she goes into hospital, she will self-harm. But has stated she does not want to go on an ACCT as nothing will happen to her until the baby is taken from her*."

In the entry seen by the Court, the words "*Midwife informed*" can also be seen at the end of the above entry, but written in a different pen. PCO Vaney said that he had added these words the following day, on the afternoon of the 26th September, when the midwife had happened to be visiting Ms Cleary and he took the chance to speak to her. He said, "*I believe I was in the hub office after speaking to Miss Cleary and I saw the midwife. I think the midwife had been over to the house block and that Miss Cleary had refused to see her. I can no longer recall precisely what was said between us, but I do believe I indicated to her that when Miss Cleary goes into hospital to have the baby she might be at risk of self-harm and so should be monitored. My meaning was in relation to being monitored when in hospital at the point of having the baby*." As I shall come to below, Clare Cochrane did tell me in evidence that she went to HB1 to see Ms Cleary on the afternoon of the 26th September, although she said that she had no recollection of PCO Vaney mentioning to her a risk of self-harm.

61. For the reasons I have already covered in relation to Nurse Chigovanyika, it is clear to me that PCO Vaney ought to have opened an ACCT or at least escalated his discussion with Ms Cleary to a senior officer. The failure to open an ACCT was, again, a significant lost opportunity to put in place monitoring of Rianna Cleary. Further, I have noted that none of the officers from HB1 wing from whom I have heard appeared to have seen PCO Vaney's written note. I was told that it would have been more easily seen if it had been included in the Houseblock observation book in the hub, and Victoria Robinson told me that she would have expected a matter of this

significance to be escalated to the duty SPCO and to be included in the hub book.

Events on the 26th and 27th September 2019

62. Nurse Mercy Mangwiro, the Deputy Head of Healthcare in the Prison, told me that at the start of each week day there would be a team meeting in the healthcare unit with the four team leaders and, save for a few exceptions, all the day shift nurses and healthcare assistants in attendance. She could not recall Ms Cleary being mentioned at the daily briefings prior to the 26th September 2019, but on that day the team were told that it had been decided that Ms Cleary needed to be transferred into Healthcare inpatient for closer monitoring. She told me that, while the bed was awaited, she decided to place Ms Cleary on "extended observations" on HB1 so that she would be monitored closely. She explained that extended observations were usually ordered for prisoners on HB 1 who needed an extended period of observations for their substance misuse detoxification. She said prisoners on this regime should have five clinical checks in every 24 hours; a one-to-one consultation with the nurse in the morning and in the evening, an observation during lockup at lunchtime, and visual observations by the nurse twice during the night. Nurse Mangwiro said that she was satisfied that those present had understood this direction. The HB1 Clinical Lead, who also happened to be the Shift Leader that day, was Vince Makunura. He was present and it was for him to put in place and oversee the regime. She said that she could see from the records that Ms Cleary had been entered onto the correct list on SystmOne for extended observations but, following Aisha's death, she had discovered that only one observation, on the morning of the 26th September, was recorded as taking place. Nurse Mangwiro said that she did not know why the subsequent observations had not been performed.

63. In her evidence, Nurse Mangwiro also addressed two other matters. First, she told me that on the morning of the 26th September, she had not been made aware of Ms Cleary's threat of suicide the previous afternoon; she said that

an ACCT ought to have been opened at the time, and if she had been made aware, she would have opened one that morning and this would have resulted in increased monitoring not only by the nurses, but by the operational staff (the prison officers) also. Secondly, she stated that in relation to the management of pregnant prisoners, the healthcare team was reliant on the midwives' guidance and support to identify any specific needs the woman may have and then to put in place a plan to meet those needs; this was because the healthcare nurses were not midwifery trained and midwifery is a speciality. She commented that generally communications between the midwifery and healthcare staff were minimal, they did not receive the midwives' plans, and they had no access to their badgernet records.

64. **Rebecca Kensett**, who was a Healthcare Assistant at the Prison, said that after the morning briefing she was asked to check on Ms Cleary, although she did not think that this check was intended to be part of the extended observations regime. She spoke to Ms Cleary at the gate to HB1 for less than a minute; Ms Kensett said *"…she wasn't really interested in speaking to me and she wasn't going to come to the midwife appointment"* and she left it at that. Ms Kensett said she told Harriet Tizard, who she thought was Hotel 9 (that is, the Manager in charge that day), that Ms Cleary was not intending to attend and at 09.11 hours and she made a note on SystmOne to that effect. **Harriet Tizard** told me that she could not recall this and that she was not Hotel 9 that day.

65. There was, in the evidence, a lack of clarity as to why the extended observations regime which Nurse Mangwiro put in place did not result in Ms Cleary being observed as she should have been. I heard from **Vince Makunura** who told me that he is a Registered Nurse and a Team Leader at the Prison. He attended the morning briefing and said that as he was Hotel 9 that day, therefore it was his responsibility to implement the direction and allocate staff. He said he did allocate the HB1 nurses to undertake the observations (although he also seemed to suggest that the visit by Rebecca Kensett was recorded as that morning's observation). He told me that in the

afternoon he asked Nurse Cadoso to undertake the afternoon observations; he accepted that they do not appear to have been done but he did not know why. Thereafter, he expected the nurses on HB1 to handover to each other the need for the observations. He was asked why he had not given them clear instructions to continue with the extended observations regime until told otherwise, and he said that he had expected Ms Cleary to have been transferred to the Healthcare Unit by the evening, as that had been the plan. Further, in the course of the day he had been informed that a bed was now available and he had tasked a nurse to assist with the transfer, and no-one had informed him that it did not go ahead. He did not check the situation before going off duty because, he said, he sincerely believed Ms Cleary had been transferred. He accepted, however, that because Ms Cleary had, in fact, remained on HB1, there was, in effect, no plan in place to implement Nurse Mangwiro's direction for extended observations to be performed. He accepted too that the records showed that although the nursing team on HB1 conducted extended observations overnight from the 26th to the 27th September for the other prisoners on the list, Ms Cleary was not seen at all. He accepted that this was an unacceptable failure to provide care in all the circumstances.

66. On the 26th September 2019, Rianna Cleary had an appointment for a scan and SPCO Todd told me that an arrangement had been made for the sonographer to let her know when they were ready, so that Ms Cleary would not be waiting and getting anxious. Tracey Todd said she received the call and she collected Ms Cleary who went with her onto the main courtyard, but then stopped. Both she and Carleigh Marshall, who was present, tried to persuade her to attend the scan but she refused, giving no reason. Carleigh Marshall recalled saying something like, *'It's not for you. It's for the baby. What if the umbilical cord is wrapped round baby's neck? We need to make sure baby's okay*' and that Ms Cleary had replied, *'No, my baby is fine*'" and had then walked back to HB1. She did not remember Rianna being in pain or upset. SPCO Todd said she later went to find SPCO Brian Rodd and Clare Cochrane, who were together in the Prison café, and she told them of Ms Cleary's refusal to attend.

67. SPCO Rodd said that, after learning of this, he went to HB1 to see Ms Cleary. He did not know about her threat of self-harm the previous day and, he said, if he had known, he would have opened an ACCT and put in place a high level of observations. He found Ms Cleary to be very quiet. He followed her around and was talking to her for about 45 minutes. He said he told her that a decision had been taken to transfer her to the Healthcare Inpatient Unit for her own welfare and safety, in view of her non-engagement with maternity, and he thought he may have offered her the option of a shared cell on HB1, but she did not agree to either of these proposals. He agreed that, at this stage, his main concern was that Rianna would give birth in her cell by herself, and he was asked whether there was any discussion with the operational staff on HB1 about the extent to which they were observing Ms Cleary. He said that SPCO Tracey Todd was present for part of his conversation with Ms Cleary and he spoke to her afterwards. He said that he thought that "*… the easiest thing for her to do would have just been to have mentioned it in the brief that she gives either in the morning or the afternoon before the next set of regime or shifts start*", but he did not suggest to me that he had expressed this to SPCO Todd. SPCO Brian Rodd agreed that he could and should have reflected the events of that morning in a NOMIS entry to bring it to the wider attention of staff, but he did not do so. SPCO Tracey Todd said she could not recall being present when SPCO Rodd spoke to Ms Cleary, nor any suggestion of observations or overnight checks. She said that if this had been suggested she hoped that she would have asked HB1 staff to undertake such checks.

68. All three members of the hospital team who had previously been directly involved in Ms Cleary's maternity care were present in the Prison on the 26th September. As stated above, Ms Cleary had refused to go to the healthcare unit either for her scan, or for her appointment in Dr Leslie's clinic. Dr Leslie said that she understood from Clare Cochrane and Sarah Legg that a plan was being put in place to move Ms Cleary into the healthcare unit where she would have regular nursing observations. She said that because she was new to the Prison, she had not realised that that setting may have been inappropriate for a heavily pregnant woman, nor that the Prison would not want to move Ms Cleary without her consent. Dr Leslie agreed that if she had known that Ms Cleary may have remained in her cell on ordinary location,

she would have recognised the risk of in-cell birth and would have wanted a plan for observations to be in place to address that risk. Dr Leslie accepted that she had not spoken to anyone at the Prison to clarify their plans. She was asked whether, without doing so, she had taken sufficient action to ensure the safety of Ms Cleary as her patient. She said that, on reflection, direct communication with the Prison healthcare and operational staff in an extraordinary multi-disciplinary meeting, or contact with the Head of Healthcare, was needed, but she had not fully understood the reality of how the Prison nursing team and operational staff worked.

69. Sarah Legg said she attended the Prison to support Ms Cochrane at an extraordinary multidisciplinary team meeting which had been arranged to discuss another prisoner. SPCO Brain Rodd and an officer from security were present. She said that, at the end of the meeting, she asked if there could also be a discussion about Ms Cleary and that she raised her concern that her EDD was unknown and that she was not engaging. She said that she specifically recalled insisting that Ms Cleary should be moved to healthcare inpatient immediately, saying "*Tonight could be the night, and we will be caught out*," and that she "*did not want this baby to be born in a cell in a wing in one of the house blocks*". When asked what had caused her so suddenly to be insistent upon a move, she said, "*Honestly, I do not know*". She said that she was told that there were no spaces available in the unit but, she said, she did not then explore what other steps should be taken if that remained the case. Ms Legg agreed that she did not make a record of this meeting on SystmOne, and that Ms Cochrane's note of that day, which stated, "*History: Unknown gestation. Consultant review: Did not attend. Plan: To continue to try and get Rianna to engage with maternity services.*", made no reference to Ms Legg's insistence on a transfer to healthcare. Ms Legg did not return to the hospital that day but she said that she was in the hospital the following morning, the 27th September, when she learned of Aisha's death. She agreed that later, at 12.36 hours, she made an entry on the badgernet records which stated, "*Rianna's case was discussed and there was discussion around Rianna being moved to healthcare. I strongly requested that Rianna be moved to healthcare today as we have no idea of Rianna's gestation. Informed that no bed is available in healthcare at present*." She accepted that the note ought to have been marked as a retrospective entry and she could not explain why it was not. She also agreed

that it had been quite wrong to record that the midwifery team had "no idea" of Ms Cleary's gestation.

70. SPCO Brian Rodd confirmed that Ms Cleary had been discussed at the meeting and, he said, matters were reviewed to bring Sarah Legg up to speed. He said he knew that Ms Legg was in favour of Ms Cleary being transferred to the healthcare unit but he could not recall her specifically stating or insisting on that in that meeting. He said there was discussion as to what else could be done and, "… *we were unable to come up with any further initiatives.*" He said that the matter was left for escalation to others the next morning.

71. In her evidence about the day, Clare Cochrane said that as Ms Cleary had not attended, before leaving the Prison, she went to see her in her cell; the door was open, and I just said, "*Hello, Ms Cleary*," and she just said, "*Please go away*." Ms Cochrane accepted that, on the basis of what she now knows, Ms Cleary was probably in the early stages of labour at that time, but she said that from that brief encounter she did not see any signs of that. She said she left the Prison and returned to the hospital where, at 19.06 hours, she sent an email to the generic Prison healthcare address, and to SPCO Rodd and Caroline Dixon, stating,

    "This lady did not attend for her antenatal appointment this afternoon. I went to her house block and spoke to her from the doorway. She was polite but insistent that I should go away. Can staff please continue to monitor closely and encourage her to engage with maternity services? She has not had a scan, so the EDD remains unknown. Rianna has stated that she is due in November, so if this is the case, she is somewhere between 31 and 35 weeks' gestation. Maternity services will continue to try to engage with Rianna on a weekly basis."

    Ms Cochrane accepted that she ought, in fact, to have indicated that the baby could arrive at any time. In response to questions from Ms Sikand KC, Clare Cochrane also accepted that she had not at any stage tried to explain the early signs of labour to Ms Cleary, or to get anyone else to do so.

72. I will note too that Harriet Tizard, the prison nurse, responded to Ms Cochrane's email at 19:49 hours, stating, "*Many thanks for this information, Clare. I have asked that she is moved to healthcare in the morning so that we can encourage engagement and monitor closely*." She also sent an email to prison colleagues indicating that she felt strongly that Ms Cleary should be moved to the healthcare unit at the earliest opportunity, and she asked for assessment and progress in the morning. She was asked why she did not take immediate action and she said that she thought Ms Cleary was being monitored overnight by the nurse on HB1 because she was on extended observations.

73. SPCO Brian Rodd also gave evidence about the note he made of the events which occurred on the 26th September 2019. He said that on the morning of the 27th September, after he had learned that Ms Cleary had given birth in her cell, like Ms Legg, he too made a retrospective entry on NOMIS, which stated,

    "I have been to see Ms Cleary today and asked her to engage with the sonographers. She refused to engage again and would not have a conversation with me. She listened to what I had to say, but refused to attend and would not give any indications as to when she was due to give birth. She is still very resistant to speaking about her pregnancy, but this has been escalated to houseblock manager on Houseblock 1 and to SPCO Todd. I have also spoken about Ms Cleary at the healthcare care plan meeting and it was agreed that observations would be carried out on the houseblock as there is a nurse available 24 hours a day. At this meeting I explained that during the day the concern was minimised as Ms Cleary was attending classes, but that during lockup she should be checked, as we're not sure when she will be due."

    Although that entry was made on the morning of the 27th September, it was dated the 26th September and was not stated to be retrospective. SPCO Rodd agreed that the account it contained was materially inaccurate in that he had not put additional observations in place, nor specifically requested them.

74. I have not yet made reference to the evidence provided to me by **Rianna Cleary**, which was read. She told me a little about background matters, but in relation to her pregnancy and the events of the 26th and 27th September, her evidence included the following:

"I realised I was pregnant in February 2019 after the police arrested me and they carried out a pregnancy test at the police station, which was positive. After that, from the moment I got back to the hostel, I felt as though all of the staff – at the hostel and the social workers - knew about my pregnancy and I felt overwhelmed with all of the questions they were asking me. I felt like they were already making decisions about me and what would happen to my baby and I didn't have the chance to think about what I wanted. I felt like I was being treated like a child not an adult. I didn't want to stay at the hostel because of that and I did not want social services to know any more about me.

I went into prison on 14 August 2019 … When I was in prison, I still felt like other people were making decisions for me and I was not involved. I was told by prison officers that I was detached from my child and a tutor in the education department told me that I would only get five minutes with my child and the police would be there to take the baby away.

There was a Camden social worker called Ruby Price who visited the prison. She was Aisha's social worker. I mostly refused to see her but I think that the prison staff were seeing her when I wasn't there because I believe that the comments that the officers were making to me - about removing my baby - were actually decisions and information being passed on from Camden social services. I felt like nobody was trying to understand me or what was going on for me. This made me defensive and I put up barriers …. I was the one who would be carrying her for nine months, but they were saying that I was detached from her. I felt like they were unfairly judging me and not giving me a chance before she was even born. I felt like I was being asked to give up on my child and motherhood.

When I was in prison, I received a letter from Camden social services dated 19 August that said that they were going to go to court to take my baby away from me and that I needed to get a lawyer. … They basically wanted to take my baby away from me because they did not think I could be a good enough mother. I found these letters extremely intimidating and upsetting and I did not know what to do about it….. . In prison, I was with other women who, it seemed to me, were getting lots of chances and their children did not seem to be getting taken away from them as far as I understood. … I don't remember any discussions about the mother and baby unit and no one told me how to apply, or helped me to do so.

I didn't get on with the midwife who came to prison. From the first time I met her she immediately started asking me personal questions, including questions about the baby's father and where he was. I didn't understand why they were asking me this and it felt intrusive, especially because this was my first meeting with her. I find it very difficult to talk about my past and my personal life, especially with a stranger. … . I felt like whatever I said to her would get passed on to social services and that

she would speak to the prison officers about me. I felt suspicious as most of her questions were about the father, not the baby, and I didn't feel like I could trust her. I did say that I had a child before, but this was not the case. Aisha was my first and only pregnancy. I only said that to try and make her back off - I thought she would stop asking me these questions if she thought that I knew more about being pregnant, but she actually asked me even more about that. The midwife told me that I was X weeks pregnant, I can't remember now what she said, but I just accepted what she told me and she said that she would book a scan. I did see the midwife another time and, on that occasion, she touched me and felt the baby moving inside me.

On another occasion, officer Brian Rodd told me that he was taking me to see the midwife, but he wouldn't say what for. I went with him down to healthcare and the midwife was there. She had a large needle. I had no idea what this was for and had not been informed that this would be happening. I am terrified of needles and I couldn't go through with that.

I did attend some of the pregnancy classes in prison, but I can't remember how many. I remember that the classes included other pregnant women, but it was a constant reminder to me about the threats that were being made to take my baby away.

I wasn't aware of any care plan and I wasn't involved in any meetings with the prison staff. Also at that time, I didn't have my own social worker until after Aisha's death, when I met my personal advisor from Camden social services. …

26 September 2019

I woke up that morning at about 6am or 7am and I felt like I needed to pee really badly. … It was a really long pee, it just kept going and going. … I can't really remember much of the daytime. We had breakfast, I was okay, I felt fine. We went to education and I was fine, but I kept feeling like I needed to go to the toilet every five or ten minutes. It came to lunchtime and I felt cramping pain, like I needed to go to the toilet, and I stood up in English a few times until the pain went away for a bit. If this was a contraction, I did not know. English class then finished at about 3.30pm.

Later, I felt like I really wanted to have a bath, a hot bath and just lay there. I was chatting with a friend of mine … and telling her that I felt like I wanted a bath. During the banter she made a comment about going into labour and I just brushed it off as we were laughing and I just didn't think that this was happening. I didn't know when I was due to give birth and I thought, from what I had been told by the midwives, that it may have been later, possibly October, but I cannot now remember what they had said to me. I didn't think that I would be going into labour now.

After dinner, I fell asleep in my cell at about 5.30pm, I know because I slept through my TV programs that I usually watch in the evening. I woke up later in the evening and I was in some real, serious pain; like really serious. I went to the buzzer and I asked for a nurse or an ambulance twice. I don't remember the time but I understand from the PPO report that the time of the buzzer was 8.07pm. I asked the officer for a nurse or an ambulance. The officer on the buzzer asked me 'what for?' I said 'I don't know just get me a fucking nurse or an ambulance'. At the time, I didn't know why I needed a nurse or ambulance, I just knew that I was in a lot of pain and I needed one. … I didn't understand why he was asking me questions when I needed help so badly. I was feeling really bad cramping pain and I was really hot – I had to take my clothes off because I felt so hot, so I was naked. No one came to see me.

I made my way back to the buzzer again and I pressed the buzzer a second time. By this time there was blood on the bed, my hands, and where I was holding on to the wall. I don't remember the time now, but I understand from the PPO report that it was 8.32pm when I pressed the buzzer a second time. However, at the time, it felt to me like hours had passed since I first pressed the buzzer. This time, no one answered it. It rang out but no one spoke. It took me ages to get from the bed to the buzzer and back again, so I was standing there for ages, and I know no-one answered or spoke to me.

After I had this call on the buzzer, it took me ages to get back into bed. … I did not know what was happening to me. I just knew I needed help. It felt like I was having a seizure – my legs were shaking. I was scared. … I think I may have been having contractions, but I didn't know that at the time. …

I remember an officer coming around and flashing a light in. It was nightly checks …. I remember I was on all fours on the bed and I was in so much pain. … I couldn't even scream, or call out, it was just constant pain. … The last thing I remember was that I was watching this film on the TV called 'Killer Joe'. There is one particular scene involving a chicken leg and that is … the last thing I remember before I passed out. I don't remember what time this happened at, but I now know that this film was shown on TV at 1.40am on 27 September 2019, according to the PPO report.

Morning of 27 September 2019

… When I woke up in the cell I was on the bed and Aisha was on the bed too, between my legs. Aisha's body was in a straight position and the cord was still attached at this time. The placenta was on the floor. Aisha was a purplish colour and she didn't seem to be breathing. There was blood everywhere. … I didn't know what to do but I just felt that I should cut the cord. I put Aisha on a towel, I bit the cord and tied it, and I put the placenta in the bin. … I got back into the bed with Aisha and I sat

holding her. … Two prisoners came to my cell first and they called the nurse. … After that, everyone came into my cell and we went to the hospital in the ambulance."

75. **PCO Mark Johnson** told me that he was an experienced PCO and on the evening of the 26th of September 2019 he was a late stay back in the "Papa 3" role, which meant he was working until 21.00 hours in a floating role. He said that at about 18.00 hours he was asked to help with the pre-lock-up regime on HB1. On arrival in the hub he did not receive information about the prisoners there; he could see which prisoners were on ACCTs, but not which prisoners were pregnant or on extended observations. He said that once the prisoners had been locked up, the other officers went off duty save for PCO Lewis Kirby who was on the late shift. PCO Johnson told me that he was in the hub when he answered a cell bell call from Cell B-28. The records show that this was at 20.07 hours. He did not know who was in that cell and so he did not know that he was speaking to Ms Cleary and he did not know that the prisoner he was speaking to was pregnant. In the account he gave to me, PCO Johnson stated,

    "*When I answered the call, I asked, "How can I help?" It was, "I want a fucking nurse." I asked, "What would you like the nurse for?" I was told, "I want a fucking nurse." And I asked again, "I need to know what you need the nurse for." And again I was told, "I want a fucking nurse." Then at that point I said, "Ms, can you give us anything?" "No. I want a fucking nurse." And then it just went quiet. After it went quiet, I had another call, another buzz came through. And I answered that one".*

    He said that Ms Cleary had asked only for a nurse and not an ambulance. He also told me that he did not bring the call from Ms Cleary to a formal end and he did not give Ms Cleary any indication of whether he would call a nurse or not. The second call was from a prisoner asking for a listener (which is someone to whom prisoners can speak for support). The records show that a call was subsequently made from the hub to Ms Cleary's cell but PCO Johnson said that he did not make that call.

76. PCO Johnson told me that, at this time, he was also receiving calls from the central control room to say that he was needed in House Block 3 immediately and so, as soon as PCO Kirby came back into the hub, he handed over the two prisoners' requests, giving their cell numbers. He said that PCO Kirby

said "*OK*", asked for the cell numbers again which he gave him, and then he left the HB1. He said he mentioned to PCO Kirby that the prisoner who wanted a nurse had been abusive, which, he said, was based on the fact that she had sworn when requesting a nurse. He said that when, later that evening, he returned briefly to HB1, he asked PCO Kirby whether he had arranged a nurse and he was told, "*It will have to wait until the night nurse comes in*". PCO Johnson accepted that if it were the case that he had not acted on Ms Cleary's request himself, and he had not handed it over to Mr Kirby, that would have been contrary to what was required of him.

77. I heard evidence also from **PCO Lewis Kirby** who gave a very different account of the events. First of all, he told me that in 2019 he was a PCO and that he usually worked on HB1. He described HB1 as having 140 prisoners who were housed on four spurs, which went off from a central area where there was a hub. The nurse's station was about five metres from the hub. He said there was no formal system in place by which officers on HB1 were informed if a prisoner was pregnant. He said, however, that he was aware of Ms Cleary and that she was pregnant, but no specific concerns about her health or welfare had been brought to his attention, either when he came on duty at lunchtime on the 26th September or previously. He did not know that she had mentioned self-harm on the 25th September.

78. PCO Kirby said that he could recall there was a prisoner who requested a listener that evening. This was arranged and he recorded this in the wing logbook where, he said, he always recorded all occurrences. He said, though, that he had no recollection of PCO Johnson telling him anything about a prisoner requesting a nurse. He said he made this clear from the first time he was asked about PCO Johnson's account. He said that he had told previous investigations that, "*If a buzzer goes and I answer it and the person says, "I need to see a nurse" or they explain an illness or something that's wrong, the first place I go to is the nurse's station and tell them. Then I know that's out of my hands. That's one thing less I've got to deal with. I know my procedures for that and I know that if I'd spoken to someone on the intercom who needed any medical assistance, I know that I would have done that*." He told me, "*It's very easy, it's not a difficult task to*

complete". When asked whether he had made a call back to Ms Cleary's cell, he said, "*Absolutely not*". He said, "*If I had been asked to get a nurse for Ms Cleary then I would have done; it was easy to fetch a nurse and I always did it whenever I was asked*". He was asked whether, if a request for a nurse had been handed over to him, he would have stated, "*This will have to wait for the Night Nurse*" and he said he would not and, in any event, a nurse was always present and he would not refer to the "*night nurse*" as such.

79. I have had to consider which account of these events I prefer and I have no hesitation in concluding that I prefer the account of PCO Kirby to that of PCO Johnson for two principal reasons. First, I found PCO Kirby to be a patently honest and reliable witness who has given consistent accounts throughout. I find also that his account of knowing about the prisoner's request for a listener, but not knowing about Ms Cleary's request for a nurse, is supported by his contemporaneous record keeping. In contrast, I do not consider that PCO Johnson was a reliable or entirely honest witness. He gave a series of accounts from October 2019 onwards which were materially inconsistent. For example:

- in October 2019 he stated to the Sodexo investigation that when he asked Ms Cleary why she needed a nurse she said, "I'm not telling you"; he said he had told her that he would get her a nurse; he said that Ms Cleary had told him to "fuck off"; and he said that he had not subsequently asked PCO Kirby whether the request had been actioned,
- in October 2019 he told the police that he had said to Ms Cleary that he would get a nurse if she told him why she needed one; that she sounded angry but not distressed and he had no cause for concern; and that he did not return to HB1 again that evening,
- in March 2021 he was interviewed again by Sodexo and he stated, for the first time, that when handing over to PCO Kirby he had written the cell numbers down on a post-it note and PCO Kirby had repeated them back to him, and that he had not subsequently asked PCO Kirby whether he had contacted the nurse.

Secondly, I heard evidence from Michelle Brown, Head of Security and Operations at the Prison, who said that the Prison's recent investigation of the

CCTV footage and call records had established that only PCO Johnson was in hub when the call back to Ms Cleary's cell was made, and PCO Johnson did not dispute that evidence.

80. I find that PCO Johnson did make the call back to Ms Cleary's cell and that he did not then handover her earlier request for a nurse to PCO Kirby. Further, PCO Johnson did not take any steps to arrange for a nurse to attend either then or when he later returned to HB1, and this despite the fact that a nurse was present on houseblock. This failure was entirely contrary to the officer's training and, I find, showed on his part a complete disregard for his responsibilities to a prisoner who was locked in a cell for the night with no other means of seeking medical assistance. I find too that his response was in no way justified by the fact that Rianna Cleary had sworn at him. If he had checked Ms Cleary himself or, as he should have done, arranged for the nurse to attend, it would have been immediately apparent that she was in labour and transfer to hospital would have followed. PCO Johnson's failure therefore resulted in a further loss of an opportunity for Ms Cleary to receive medical assistance with her labour and delivery.

81. Ms Cleary's second call from her cell was made at 20:32:49 hours and the records show that, as this was not answered within one minute on the HB1 hub, it was forwarded to the central communications room where it was answered at 20:45:48 hours, with the call being ended one second later. **Daniel Davies** told me that he was working as an Operational Support Officer in the Communications Room at the time that Ms Cleary's call came through. He said he was working alone and it was a busy night. He agreed a cell call would remain on the system until it was answered, subject only to there being a fault in the system. He told me that he could not recall specifically a call from cell 1-B-28 coming up on the screen. He was aware that the records indicated that Ms Cleary's call, and a number of other calls, had been answered and then almost immediately cancelled. He was asked whether he had answered Ms Cleary's call and then cancelled it without speaking to the caller. He said he could not remember doing that and that it was something he would never do because he understood the importance of answering calls for the welfare of the prisoners. He was asked whether he could explain what else may have happened; he said it was possible that he

had accidentally cancelled the call, although he said he could not remember whether that meant that the call would first have to have been answered or not; and he said that there were occasions when the calls would drop from the system, either whilst speaking to the prisoner or before the call was answered; he said he had never formally reported this problem to the IT department but he had mentioned it at some point. I heard evidence from the Prison as to the cell call system and whether there was any indication of a fault. **Robbie Matharu**, Technical Operations Manager, stated ,*"I have checked the historic records and there are no reports of any issues relating to the cell calls disconnecting or dropping from the system in 2019. I have checked the systems for any reports from the 1st January 2018 to March 2020 when the cell call system was upgraded".* Having considered all this evidence, I have not found it possible to form a final conclusion as to what occurred. OSO Davies did not seem to me to be a dishonest witness and I consider the evidence falls short of enabling me to conclude that he deliberately answered and then immediately ended the call. If that is what occurred, it would be another very serious failure. In any event, Ms Cleary's second attempt to obtain help and medical assistance were met with no response.

82. **PCO Katarzyna Rachwal** told me that she was a new officer, working on HB1, and the week of the 26th September was the first time she had been on duty as a night officer. PCO Rachwal said she knew Ms Cleary, and she knew that she was pregnant because that was obvious, but she did not know when the baby was due, and she had not been given any specific information or instructions relating to her. Ms Cleary had not been mentioned in PCO Kirby's handover. The witness explained that as the night officer she was the only officer on duty from about 20.30 hours until 07.30 hours the following day. She said that overnight it was usual for the officer to be based in the hub, unless patrolling, and for the nurse to be based in the nurses' station. The overnight duties included conducting individual observations on prisoners with an open ACCT and responding to cell calls. Further, two roll counts had to be conducted, one at 21.30 hours and the second at 04.30 hours. She said that she understood the purpose was to check that every prisoner is in her cell and to check on her welfare; the latter required the officer to see clear movement or clear signs of breathing. She said checks are conducted

through the hatch in the cell door and light can come from the officer's torch or a cell light which can be activated from outside the door.

83. I saw CCTV footage of PCO Rachwal conducting the 21.30 roll check. She explained that she had turned off the spur lights, as it made it easier to see in the cells, and had then used her torch light as necessary. She told me that she had not noticed anything of concern when checking Ms Cleary's cell, although she could not recall precisely what she had seen. She said that if she had seen Ms Cleary on all fours on her bed (which Ms Cleary suggests was her position when a torch shone into her cell) then she would have knocked and asked if she was okay or if she needed help. On the basis of what I could see on the CCTV, which showed the officer completing the checks of all the cells on the landing in less than two minutes, and spending only a couple of seconds at most cell doors, I asked PCO Rachwal whether she had been able to gain a proper view of Ms Cleary. She said that at that time of the evening most of the prisoners were still up and about, which made the task much easier. Ms Sikand KC put to the witness that Ms Cleary recalled being on all fours on the bed, but she had not seen that because she had flashed her torch for less than a second and had not looked properly before moving on. PCO Rachwal responded, "*I don't really know how to answer that. I did my check. I looked. Nothing caught my attention. That's why I moved on*".

84. PCO Rachwal said that at about 23.00 hours, PCO Sienkiewicz was deployed to provide her with support. **PCO Marta Sienkiewicz** also gave evidence. She confirmed that she was in the "Papa 1" role and that she went to HB1 to support PCO Rachwal as she was a new officer. She assisted with various tasks, including accompanying the nurse when she was carrying out her observations, and she performed the second roll check on A and B spurs. PCO Sienkiewicz said officers are required to see the prisoner and to see them moving, although visible breathing is sufficient. The CCTV showed the witness checking some cells on the upper B landing very quickly, and taking a little longer over others, but she said that she checked all the prisoners sufficiently; she said, routinely, some prisoners are still awake even at that

time and others will gesture to assist. She said she did not see anything amiss in Ms Cleary's cell; if she had seen blood, she would have raised the alarm.

85. The statement of **Joanna Holden** was read into evidence because the witness could not be located. Ms Holden was a prisoner who was accommodated in cell 1-B-13, which was on the landing below, and two along from, Ms Cleary's cell. She stated that from about 21.00 hours she was watching the television in her cell, and at about 21.15 hours she heard "*two noises*" which she described as "*the noise of a baby crying*"; she said there was a long and a short noise. She said the noises definitely did not come from the television. She commented to her cell mate who asked whether it was the television but, said the witness, she was sure it was not the television and it was definitely a baby's cry.

86. PCO Vaney told me that on the morning of the 27th September he unlocked the cells on B spur, including Ms Cleary's cell, leaving her door slightly ajar. He said he had glanced into the cell but saw nothing of note. He was approached by another prisoner who said that Ms Cleary had locked her door and that she needed a nurse. He said he returned and found Ms Cleary in tears. There was some dried blood on the floor. Other officers arrived and help was summoned. He said he then saw the crown of Aisha's head under Ms Cleary's duvet. **SO Pauline Painter** stated that after she entered the cell Ms Cleary handed Aisha to her; she was wrapped in a towel and was "covered in meconium". She said Aisha was not moving, had a tinge of blue on her lips, but was still warm. She used a stethoscope but heard nothing. Nurse Jaswant Singh entered cell. He said there was blood "everywhere", on the floor, wall, and sink, and it was dried. When he realised there was a baby, he and colleagues attempted resuscitation. He was aware of some stiffness in Aisha's limbs. There were chest compressions but no mouth to mouth resuscitation. Attempts were made to give oxygen via a bag valve mask, but there was no neo-natal or paediatric mask available and so an adult one, which did not fit or create a seal, was used. The attempts continued until the ambulance personnel arrived. Evidence from two paramedics was read and they explained that they entered the cell and took over, and provided cardio-

pulmonary resuscitation. **Adam Castelow-Sturges** stated that Aisha seemed warm to the touch but she was peripherally cyanosed, and another paramedic noted rigor mortis in Aisha's legs. Aisha's heart was asystole. Resuscitation was stopped and there was a recognition of life extinct at 09.03 hours. Aisha was then given to Ms Cleary, and they were both taken by ambulance to St. Peter's Hospital.

Post Mortem and Expert Evidence

87. **Dr Andreas Marnerides** is a Consultant Paediatric Pathologist who conducted a post mortem examination on Aisha, together with Dr Nathaniel Cary, who is a Home Office approved Consultant Forensic Pathologist. The key matters arising from Dr Marnerides' factual and opinion evidence were as follows:

    - Aisha was a full term baby, probably delivered at between 38 to 40 weeks,
    - She had no abnormalities or injuries to account for her death,
    - Aisha's lungs were structurally normal and floated in water and so they contained air,
    - Histology of the lungs showed a mixed pattern of aeration in the alveoli and airways with irregularly shaped distention of the alveoli and overdistention of the lymphatic vessels,
    - There was no milk in Aisha's stomach and so she had not fed,
    - The umbilical cord contained a single rather than two umbilical arteries,
    - The size of the placenta was in the lowest percentile and there was evidence of delayed chorionic villous maturation, which is associated with and can account for adverse outcomes, and
    - There was no maceration which showed that Aisha died either no more than 24 hours before her delivery or after her live birth.

88. On the issue of whether Aisha was born alive or was still born, Dr Marnerides stated that he could not confidently differentiate between two possibilities which were that Aisha had air in her lungs because of (i) a combination of independent breathing and ventilation/resuscitation efforts or (ii) ventilation/resuscitation only.

89. On the question of Aisha's cause of death, or the cause of her stillbirth, Dr Marnerides stated that delayed chorionic villous maturation can cause sudden intrauterine death close to term, at term or soon after birth. This is because the placenta is not able to give sufficient oxygen for the baby to deliver safely or survive once born. It is thought that, probably, a single umbilical artery exacerbates that difficulty. He said that it appears to him that Aisha's destiny had been determined by events occurring whilst still in utero, but, he said, he also recognised that uncontrolled and unassisted birth presents a high risk of mortality on its own.

90. So far as the Cause of Death was concerned, he said that in his opinion it was:

    Ia Ante/intrapartum hypoxia/ischemia

    Ib Delayed chorionic villous maturation and single umbilical artery.

91. Dr Cary's post mortem report was read. He agreed with Dr Marnerides' views and he too stated, "*I note the circumstances of labour and delivery. Whilst accepting that the prognoses for live birth could be unpredictable with underlying delayed chorionic villous maturation, it is a matter of common sense that the prognoses would have been improved had labour and delivery been properly managed*."

92. Finally, I heard evidence from two independent expert witnesses. The first was **Ms Ruth Mason** who is a Consultant Obstetrician and Gynaecologist. The key matters arising from her evidence were:

    (i) A single umbilical artery can be detected by an ultrasound scan but would have little clinical significance as an isolated finding. Delayed maturation of the chorionic villi cannot be seen on an ultrasound scan and would not be detected at an ante-natal stage,

(ii) If a pregnant woman with capacity refuses ante-natal care she can be persuaded, but not forced, to receive it,

(iii) Measurement of the fundal height is a rough screening tool that can be used to monitor the growth of the foetus. A measurement of 32 cms suggests between 30 and 34 weeks' gestation, if everything is normal with the pregnancy. In the absence of scans or any other objective evidence, it is a piece of information upon which some weight can be placed,

(iv) On the basis of Ms Cleary's description in her evidence, it is likely that her labour began on the morning of the 26th September 2019 and that it progressed through the day,

(v) It is possible for a woman in labour to pass out, perhaps through the pain, and for the delivery then to proceed to the point of birth without the woman regaining consciousness,

(vi) The absence of maceration shows that Aisha died close to the time of her deliver, either no more than 24 hours before her delivery, or after it,

(vii) If Aisha had cried vigorously (as opposed to making any lesser or no sound) after birth, then I would expect this to have roused Ms Clearly and the fact that Ms Cleary was not roused may suggest a stillbirth; otherwise, I agree with Dr Marnerides that it is not possible on the evidence to form a view as to whether Aisha was born alive or not,

(viii) It is clear from the post mortem evidence that Aisha died from a catastrophic hypoxic insult. Ms Cleary's pregnancy was high-risk and there were factors which raised the risk of a hypoxic insult. The lack of ante-natal care and absence of clinical care through the labour and delivery increased the risk of that insult occurring,

(ix) There are too many variables to know whether ante-natal care would probably have identified a relevant problem, although sequential scanning could have picked up growth concerns caused by the delayed chorionic villous maturation, if there were any; but it is impossible to know;

(x) As long as Aisha had been alive at the start of Ms Cleary's labour, the provision of clinical care may have enabled her to survive. If Ms Cleary's labour had been identified and she had received clinical care in hospital, there would have been foetal monitoring of Aisha's heartbeat. There was evidence of fresh meconium staining, indicating

foetal distress which would have been detected, and immediate delivery by caesarean section or forceps/ventouse delivery could have been performed as required. Neonatologists are asked to attend so that neonatal resuscitation can be provided immediately by ventilation or, as a last resort, intubation, if necessary, and

(xi) I am therefore of the view that if Aisha had been alive at the start of labour and if she had been monitored during the labour, my expectation would be that the monitoring would have detected foetal distress and she would have been delivered and resuscitated, and in those circumstances probably would have survived.

93. I also heard opinion evidence from **Sheeylar Macey** who is a Registered Nurse with experience of reviewing the provision of clinical care in a custodial setting and assessing whether it equates to that provided in the community. Ms Macey said that Ms Cleary's pregnancy was high risk for a number of reasons, including her refusal to accept ante-natal care. No reliable EDD was established and there was a risk of an in-cell labour. If locked in the cell, Ms Cleary's only means of summoning help was via her cell bell and this also increased the risk, and raised the possibility of an unassisted delivery, as in fact occurred. Individual efforts were made but the overall effectiveness of the care given suffered from a lack of co-ordination. In reviewing the care which preceded this she said as follows:

(i) The midwifery and obstetric resources within the Prison were quite minimal for the size and complexity of the maternity case load,

(ii) The Prison did not have a clear pathway for the management of pregnant prisoners who were not accepted for the MBU and there was no individual within the Prison with clinical responsibility for Ms Cleary in relation to her pregnancy; this resulted in an inappropriate expectation of what SPCO Rodd could achieve as the individual with operational responsibility for all pregnant prisoners,

(iii) There were two sets of medical records in use and the prison healthcare staff did not have access to the hospital's badgernet notes,

(iv) Given the extent, persistence, and significance of Ms Cleary's refusal of ante-natal services, which was unusual, more could and should have been done (a) to understand why she was refusing care in the context of previous trauma and the safeguarding issues arising and (b) to address how her care would be managed in the circumstances,

(v) There could and should have been more and earlier sharing of information by the midwives with the Prison healthcare team,

(vi) All clinicians could and should have been involved, through a multi-disciplinary approach, at any earlier stage so that a joint midwifery and prison plan for wraparound care could be put in place; the plan should have provided the prison healthcare and operational staff with guidance as to the oversight needed to identify Ms Cleary's labour and ensure her transfer to hospital; in fact, no-one had provided a pragmatic plan at any stage to address how the "worst case scenario" was to be avoided,

(vii) To this end, the midwifery team could and should have established greater clarity as to the likely EDD; the fundal height measurement, if taken into account, would have provided a likely window for Aisha's arrival from the 24th September to the 14th October, and

(viii) Overall, Ms Macey concluded that the clinical care provided was not equivalent to that which might have been expected in the community, even taking account of Ms Cleary's own refusal of treatment.

Findings as to Live Birth or Still Birth and Medical Cause of Death

94. I will record the test which I have applied when considering whether Aisha was born alive or was stillborn. The "*Chief Coroner's Guidance No.45, Stillbirth, and Live Birth following Termination of Pregnancy"*, at para. 3, points coroners to the definition of stillbirth in the *Births and Deaths Registration Act 1953, s.41,* as amended, which states,

"For the purposes of death registration, a stillborn child is one which has issued forth from its mother after the 24th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life."

95. It is clear from the evidence that Aisha was either born alive and died shortly afterwards, or she died before her delivery, but not more than 24 hours earlier. I have concluded that there is evidence to suggest that Aisha may have been born alive and died shortly afterwards, but that whilst this is a possibility, the evidence is not sufficient to enable me to find that this is probable. Similarly, there is evidence to suggest that Aisha may have been

stillborn, and this too is a possibility, but the evidence is not sufficient to enable me to find that this is probable. In the circumstances, I must treat this issue as unascertained. I have reached this view in the light of the following in particular:

- Ms Cleary was the only person present at the time of Aisha's delivery. She saw no signs of life, but she was not conscious at the time of the delivery and so her evidence cannot assist one way or the other,

- The evidence of Dr Marnerides, which I fully accept, was that there was some air in Aisha's lungs and this resulted from either a combination of independent breathing and ventilation/resuscitation efforts or ventilation/resuscitation only, and he could not confidently differentiate between those two possibilities,

- Ms Mason said if there had been vigorous crying by Aisha (as opposed to a small whimper) she would have expected that to wake Ms Cleary, but it is axiomatic that it is possible that Aisha was born alive but did not cry vigorously, and I do not consider that this assists me, and

- Joanna Holden states that she heard two baby cries. However, her cell was some distance from Ms Cleary's, the time at which she suggests she heard the cries does not accord with Ms Cleary's evidence as to the likely time of delivery, and as I was not able to locate this witness and I was therefore unable to hear oral evidence from her, it is impossible to assess the reliability of her evidence and I must treat it with great caution.

96. So far as the medical cause of death is concerned, I agree and adopt that proposed by Dr Marnerides and Dr Carey, which is uncontentious.

97. As for the date and time of death, on the basis of Ms Cleary's evidence, I find that Aisha was probably delivered on the 27th September 2019 at some time after 01.40 hours. I am satisfied that if Aisha was born alive, she had already died by the time Ms Cleary's cell was unlocked on the morning of the 27th September 2019. In this regard, I note that Aisha was found to have a degree of rigor mortis shortly after she was found.

B. CONCLUSIONS

98. On the basis of the evidence I have heard, and the findings I have made, I have reached the following conclusions:

a) Aisha's mother, Rianna Cleary, was a vulnerable teenager throughout her pregnancy. It is right to acknowledge that, save on a few occasions, she declined offers of ante-natal care. Her refusal to engage with maternity services became more resolute after she had been told that Aisha may be removed at birth. The state agencies and clinicians ought to have understood, and ought to have taken account of the fact, that Ms Cleary's traumatic background and the prospect of her baby being removed from her were likely to have affected her willingness to engage.

b) Rianna Cleary ought to have had the support of a Personal Advisor and a Pathway Plan. A Personal Advisor would have had an important role to play in providing her with personal support through what was inevitably going to be an emotionally and psychologically difficult process of her pregnancy in prison with a prospect of her baby's removal.

c) The Prison did not have in place a pathway for the care of a pregnant prisoner who was not going to be housed in the MBU, and no-one within the Prison was identified as having clinical responsibility for Ms Cleary in relation to her pregnancy.

d) Ms Cleary's pregnancy was high-risk and by early September 2019 it was apparent, and it was recognised, that she had become resolutely unwilling to engage with maternity services and that there was a consequential high risk that she might give birth alone in her cell.

e) Despite these risks, the midwifery and obstetric service from St. Peter's Hospital failed to:

- give reliable guidance as to the time at which Aisha was likely to arrive,
- take a joint working approach with the Prison's healthcare team (nurses and GP),
- arrange a multi-disciplinary team meeting, and
- ensure that an effective joint plan was in place to ensure that Ms Cleary's labour was identified and that she was transferred to hospital in a timely manner for Aisha's delivery.

f) Despite these risks, the Prison failed to:

- put in place an effective plan to ensure that Ms Cleary's labour was identified and that she was transferred to hospital in a timely manner for Aisha's delivery,
- put in place a clear and effective plan to observe and monitor Ms Cleary,
- open an ACCT when Ms Cleary spoke of self-harm in the context of her pregnancy on the 25th September 2019,
- implement the extended observations regime that had been directed on the morning of the 26th September 2019, and
- respond to Rianna Cleary's request for medical assistance at 20.07 hours on the 26th September 2019, when she was locked in her cell and in labour, and failed to answer her second cell intercom call made at 20.32 hours that evening.

g) The provision of a Personal Advisor, and a more trauma informed approach by those in contact with Ms Cleary, may have increased the chance of her engagement with ante-natal services, but for the reasons set out in the evidence of Ms Mason, which I accept, I have concluded that there is no more than a speculative chance that this may have identified any risk to Aisha prior to the start of Ms Cleary's labour.

h) However, if Ms Cleary's labour had been identified and she had been transferred to hospital in a timely manner for Aisha's delivery, there would have been an opportunity for effective steps to have been taken to secure Aisha's survival, as described by Ms Mason.

C. RECORD OF INQUEST

Legal Submissions

99. At the close of the evidence I received written and oral legal submissions from the Interested Persons as to what I may or must record on the Record of Inquest. I have taken account of all the submissions I received.

100. For the reasons I have already given, I have found that I am unable to ascertain whether or not Aisha was born alive. This is because the evidence which suggests that she may have been born alive is insufficient to meet the requisite standard of proof, which is the balance of probabilities. I heard competing submissions as to what I may or must record in these circumstances.

101. I have considered the relevant obligations which arise from the Coroners and Justice Act 2009 ("the 2009 Act") and the Coroners (Inquests) Rules 2013 ("the 2013 Rules"). Section 10 of the 2009 Act states that a coroner must make a determination as to the questions in section 5 (1) (a) and (b) of the 2009 Act, which are who the deceased was and when, where and how the deceased came by his or her death, and a finding as to the particulars required by s. 5 (1) (c) of the 2009 Act.

102. Rule 34 the 2013 Rules 2013 states,

*"**Record of Inquest***

34. A coroner or in the case of an inquest heard with a jury, the jury, must make a determination and any finding required under section 10 using Form 2."

Form 2 is found in the Schedule to the 2013 Rules. It is headed "*Record of Inquest*" and consists of five sections, one of which calls for a "*Conclusion … as to the death*". Notes to Form 2 state,

"(i) One of the following short-form conclusions may be adopted:-

I. accident or misadventure
II. alcohol / drug related
III. industrial disease
IV. lawful / unlawful killing
V. natural causes
VI. open
VII. road traffic collision
VIII. stillbirth
IX. suicide

(ii) As an alternative, or in addition to one of the short-form conclusions listed under NOTE (i), the coroner or where applicable the jury, may make a brief narrative conclusion."

103. The combined effect of rule 34 and the Notes to Form 2 is that, even if there is a finding of stillbirth following an inquest, a Record of Inquest must be completed in which a "*Conclusion … as to the death*" [my emphasis] must be recorded. This is apparent from the fact that "*stillbirth*" is one of the potential conclusions listed in the Notes to Form 2. Further, the *Chief Coroner's Guidance No.45*, at para. 18, states, *"Where it has been found at an inquest that a child was stillborn, the short-form conclusion of 'Stillbirth', which is listed in Note (i) in the Schedule to The Coroners (Inquests) Rules 2013, should usually be used."* The *Chief Coroner's Guidance* does not proceed to address whether, and if so how, the remainder of the Record of Inquest should be completed if there has been a finding of stillbirth. It was submitted to me that if there is a finding that a baby was stillborn and never lived, the other questions on the Record of Inquest do not arise because there cannot have been a death (see *Chief Coroner's Guidance No.45* at para. 4 and the *Attorney General's Reference (No.3 of 1994)* [1998] A.C. 245). I have my doubts as to the correctness of this submission given the wording of the statutory regime

introduced by the 2009 Act and the 2013 Rules, but for present purposes I do not need to resolve that issue.

104. What I have to decide is what I must or may record on the Record of Inquest given that I am unable to ascertain whether Aisha was or was not born alive. I have received conflicting submissions. I will not review them all, even though I have read and considered all of them. I will though note, in particular, that some Interested Persons argued that I do not have jurisdiction to complete a Record of Inquest in full.

105. In her written submissions on behalf of Sodexo, Ms Richards KC submitted that,

"*If, having considered all the evidence, the Coroner is unable to determine whether Aisha was stillborn or born alive, no conclusion (short form or narrative) should be recorded by way of determination under sections 5 and 10".*

This follows "… *from the fact that, unless there has been independent life, the Coroner has no statutory jurisdiction to determine how the baby came by its death."*

In her oral submissions, Ms Richards KC stated that it was, in particular, box 3 on the Record of Inquest which I may not complete. Mr Waite argued for the Ministry of Justice that a positive finding of live birth is a condition precedent to the duty arising under section 10 of the 2009 Act. Ms Christie-Brown, for Ashford and St. Peter's, pointed to the fact that death registration documentation treat stillbirths, and deaths where the issue is unascertained, in the same way. On that basis, she argued that I should complete the Record of Inquest by entering "stillbirth" and/or a brief narrative conclusion in box 4, but recording no other determination.

106. I reject these submissions. In my view, there is a material difference between a positive finding of fact that a baby was stillborn and did not live at all, and my finding with regard to Aisha. In this inquest I have found, on the basis of the evidence, which I have accepted, that Aisha may have been born alive. I can see nothing in the wording of the 2009 Act or the 2013 Rules which precludes me from recording my determinations and findings in these circumstances. Section 10 of the 2009 Act makes reference to determinations

about the death and I consider that my finding that Aisha may have been born alive and died is sufficient to permit and, indeed, to require me to record my relevant findings on the matters raised in section 5 of the 2009 Act. I consider that it would be wholly wrong for me to treat Aisha's death as if I had made a finding of stillbirth and to record that as my conclusion.

107. I also received submissions from the Interested Persons in relation to the engagement of Article 2 of the ECHR and whether this is affected by my finding as to whether Aisha was or was not born alive. As I have stated above, it was agreed at a pre-inquest stage that this inquest should comply with the procedural duty arising under Article 2 and it has done so.

108. On behalf of Rianna Cleary, Ms Sikand KC submitted that if I found that Aisha was born alive, then Article 2 would undoubtedly be engaged. Although case law does suggest that there is no duty on the State to protect the life of a foetus, Ms Sikand pointed to *Chief Coroner's Guidance No.45*, at para. 25, which states,

"*Coroners should bear in mind that a child who is born alive following a termination of pregnancy has the same rights as any other person in this jurisdiction, including the Article 2 Right to Life. This means the child should receive the same life-saving treatment, or palliative care, as would be appropriate for a child in the same condition whose birth occurred naturally*".

Ms Sikand KC also argued that, "*In the context of a pregnant prisoner who gives birth in prison in her cell and without medical (or other) assistance, she is entirely dependent on the care of the State which has assumed responsibility for her welfare and safety, and given the unborn child's intimate connection to her, so is the child so dependent. Thus, even if baby Aisha herself was not technically a prisoner, she was born in a prison cell and was wholly dependent on the State. She was therefore in the control of the State, whether technically detained or not*."

No Interested Person sought actively to argue that Article 2 would not be engaged if Aisha had been born alive. Ms Richards KC stated, "*we don't make a positive submission that Article 2 is not engaged in those circumstances*".

109. Ms Sikand KC went on to argue that if a live birth cannot be ruled out, I must proceed on the same basis, as Aisha may have been alive and her death may have been more than minimally contributed to by the State's failings.

110. I agree with and accept both the submissions made by Ms Sikand KC in this regard. I am satisfied that the findings I have reached form a sufficient basis to conclude that Article 2 is engaged, as long as I have found, which I have, that Aisha was or may have been born alive. There is clear evidence, not least, of systemic failings which more than minimally contributed to Aisha being delivered in a prison cell without medical assistance and, following delivery, losing the chance of resuscitation and survival.

Record of Inquest

I shall, therefore, record the following on the Record of Inquest :

Box 1 :

Aisha Cleary

Box 2 :

Ia Ante/intrapartum hypoxia/ischemia

Ib Delayed chorionic villous maturation and single umbilical artery

Box 3 :

See Box 4

Box 4 :

On the evening of the 26th September 2019, Aisha Cleary's mother, who was in custody in HMP Bronzefield, was locked in her sole occupancy cell in Houseblock 1. She was in labour and, at some time between 01.40 hours and 07.30 hours on the 27th September 2019, she delivered Aisha. Aisha suffered an acute ante/intrapartum hypoxia/ischaemia by reason of placental delayed chorionic villous maturation and a single umbilical artery. It is possible that Aisha was born alive and died shortly thereafter and it is possible that she was stillborn and had died up to 24 hours earlier. The evidence did not enable a finding to be made, to the requisite standard of proof, as between those two possibilities. When prison staff entered the cell on the morning of the 27th September 2019, Aisha was found to be dead and she was formally recognised as life extinct at 09.03 hours.

Aisha's mother had been in custody at the prison since the 14th August 2019. She was a vulnerable teenager whose pregnancy was high-risk and who, by reason of her vulnerabilities, refused most of the ante-natal services which were offered to her by the midwifery and obstetric team from Ashford and St. Peter's Hospitals NHS Foundation Trust. By early September 2019, there was a recognised risk that she could give birth alone in her cell if her labour was not identified and she was not transferred to hospital in a timely manner for Aisha's delivery.

Despite these risks, the midwifery and obstetric team failed to:

- give reliable guidance as to the time at which Aisha was likely to arrive,
- take a joint working approach with the Prison's nursing and General Practitioner healthcare team,
- arrange a multi-disciplinary team meeting, and
- ensure that an effective joint plan was in place to ensure that Aisha's mother's labour was identified and that she was transferred to hospital in a timely manner for Aisha's delivery.

Despite these risks, the Prison failed to:

- put in place an effective plan to ensure that Aisha's mother's labour was identified and that she was transferred to hospital in a timely manner for Aisha's delivery,
- put in place a clear and effective plan to observe and monitor Aisha's mother,
- open an ACCT when Aisha's mother spoke of self-harm in the context of her pregnancy on the 25th September 2019,
- implement the extended observations regime that had been directed on the morning of the 26th September 2019,

- respond to Aisha's mother's request for medical assistance made to a prison officer via her cell intercom at 20.07 hours on the 26th September 2019, at which time she was in labour, and
- answer a second cell intercom call made at 20.32 hours that evening.

If Aisha's mother's labour had been identified and she had been transferred to hospital in a timely manner for Aisha's delivery, there would have been an opportunity for effective steps to have been taken to secure Aisha's survival.

Box 5 :

(a) 27th September 2019, HMP Bronzefield

(b) Aisha Cleary

(c) Female

(d) -

(e) 27th September 2019, HMP Bronzefield

(f) -

I would like to record my thanks to counsel for their work and assistance, which I have appreciated, and to pass my very sincere condolences to Rianna Cleary.

Richard Travers
HM Senior Coroner for Surrey

28th July 2023