Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Magdelena Luczak, a prisoner at HMP Foston Hall, on 14 July 2015

A report by the Prisons and Probation Ombudsman

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Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Luczak was found hanged in her cell at HMP Foston Hall on 14 July 2015. Ms Luczak was 29 years old. I offer my condolences to Ms Luczak's family and friends.

Ms Luczak had been convicted of murdering her own child, was not allowed to see her other children, who had been adopted, and was facing a very long time in prison before she had any hope of release. The circumstances of her offence attracted a great deal of publicity. During her time in prison, she was subject to abuse from other women prisoners and had little outside support. A number of staff at Foston Hall gave Ms Luczak good support during her time there. Ms Luczak had been managed under suicide and self-harm prevention procedures a number of times at Foston Hall and had been saved from suicide by the quick actions of staff in 2013.

The investigation found that Ms Luczak engaged in illicit drug use and some dubious relationships with other prisoners, about which staff did not take sufficient action. There were deficiencies in the suicide monitoring procedures, which ended two weeks before her death. However, Ms Luczak was always likely to be at significant risk of suicide and I consider it would have been difficult for staff to have identified that she was at imminent or particularly high, risk, at the time of her death. There were also problems with the emergency response, which the prison will need to rectify, but, this would not have changed the outcome for Ms Luczak.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

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Summary

Events

1. In March 2012, Ms Magdalena Luczak and her partner were charged with the murder of her son. Apart from three days when she was first remanded to prison, she had spent all her time at HMP Foston Hall. In August 2013, she was convicted and received a life sentence with a minimum period to serve of 30 years before she could be considered for release. Shortly afterwards, she tried to hang herself. During her time in prison, staff monitored Ms Luczak using Prison Service suicide and self-harm prevention procedures, known as ACCT, on 11 separate periods.

2. Ms Luczak had few visitors and made no telephone calls. She was often bullied because of her offence, but was also reported to have had close relationships with several other prisoners. She often used illicitly obtained drugs in prison. In 2015, she acknowledged her dependency on drugs and completed a detoxification programme in June. However, she continued to misuse drugs.

3. Ms Luczak was under the care of the prison's mental health in-reach team between 2012 and 2013 and from 2014 to 2015. In May 2015, a psychiatrist discharged her as he did not consider she had serious mental health problems. Staff monitored Ms Luczak under ACCT procedures for the final time between 19 and 30 June 2015, after she cut herself. In July, a nurse from the primary mental health team assessed Ms Luczak but did not think she would benefit from the team's input. The mental health in-reach team decided not to re-engage with her and, at the same time, a psychologist discharged her from her caseload as Ms Luczak had not engaged with therapy.

4. Ms Luczak's offender supervisor had referred her to several programmes, including an addiction treatment programme at HMP Send, but she was not accepted as it was considered too early in her sentence. Her offender supervisor planned a further forensic psychological assessment.

5. On 12 July, Ms Luczak appeared upset after having a visit from a friend. On the evening of 13 July, she was heard arguing with the woman in the cell next to her, who she had apparently been in a relationship with. At a 6.00am roll check on 14 July, a night patrol officer did not see or get a response from Ms Luczak and assumed she was in the shower room attached to her cell. About an hour later, an officer checked her and found Ms Luczak hanged in the shower room. Staff tried to resuscitate her but, shortly after they arrived, paramedics recorded that she had died.

Findings

6. The clinical reviewer found that the standard of healthcare Ms Luczak received at Foston Hall was equivalent to that she could have expected to receive in the community. He considered that the decisions by mental health staff to discharge her were reasonable and well documented.

7. Ms Luczak frequently used illicit substances, which appear to have been too readily available at Foston Hall. She also appears to have had a number of relationships

with other prisoners which might have had a detrimental effect on her wellbeing, but staff did not always take appropriate action

8. There were some deficiencies in the management of the ACCT procedures, which ended two weeks before Ms Luczak's death. There was insufficient involvement of healthcare and substance misuse staff in ACCT case reviews. The reviews did not identify the main issues Ms Luczak was facing at the time of her death and translate these into effective caremap actions to help reduce her risk. Not all caremap actions had been fully competed when ACCT monitoring ended.

9. Ms Luczak had a number of problems in the two weeks before her death. However, as she was always at long-term risk of suicide, we recognise that it would have been difficult for staff to have identified that she was at particularly heightened risk at the time. Overall, we consider that Ms Luczak received some good support at the prison and that it would have been difficult for staff to have anticipated her actions that particular day or to have prevented her death.

10. Although it would not have affected the outcome for Ms Luczak, there were a number of problems with the emergency response. The night patrol officer did not get a response from Ms Luczak during a roll count and had not been issued with a cut-down tool. There was a three-minute delay before control room staff called an ambulance. The emergency response bag was missing vital equipment. Staff attempted resuscitation even though there were signs of partial rigor mortis. Several members of staff expressed dissatisfaction with the support they had received from the prison after Ms Luczak died.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular that:
    - There is a multidisciplinary approach for all case reviews, with healthcare staff attending all first case reviews and subsequent reviews where relevant.
    - ACCT caremap actions are specific and meaningful, address all of the issues identified during the assessment interview and case reviews and that ACCTs are not closed until all caremap actions have been completed.
    - All staff, including healthcare staff, record relevant information about risk, observations, and interactions with prisoners in ACCT documents, and any action taken.
    - Case managers have relevant training.
- The Governor should ensure that staff challenge prisoners in line with the local decency policy if there are justified concerns that their relationship is detrimental to the wellbeing of one of the women.

- The Governor should ensure that there is an effective supply reduction strategy to reduce the availability of illicit drugs and diverted medication.

- The Governor and the Head of Healthcare should ensure that all prison staff are made aware of their responsibilities under PSI 03/2013 and that in particular:

    - Staff account for every prisoner during roll counts.
    - All uniformed staff carry an anti-ligature cut-down tool.
    - Control room staff understand their responsibilities during medical emergencies.
    - Emergency response bags contain all necessary equipment.
    - Staff are given guidance about the circumstances in which resuscitation is not appropriate.

- The Governor should ensure that staff are appropriately supported after the death of a prisoner.

The Investigation Process

11. The investigator issued notices to staff and prisoners at Foston Hall informing them of the investigation and asking anyone with relevant information to contact him. Five prisoners asked to speak to him.

12. The investigator visited Foston Hall on 21 July. He obtained copies of relevant extracts from Ms Luczak's prison and medical records and interviewed five prisoners.

13. NHS England commissioned a clinical reviewer to review Ms Luczak's clinical care at the prison

14. The investigator interviewed 19 members of staff at Foston Hall on 16, 17 and 18 September and 13 October. The clinical reviewer joined the investigator for the interviews with healthcare staff.

15. We informed HM Coroner for Derbyshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Ms Luczak's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Ms Luczak's sister wanted to know:

    - Whether Ms Luczak had seen a psychiatrist or had psychiatric treatment.
    - What medication she had been prescribed.
    - How Ms Luczak's risk of suicide and self-harm had been managed in the light of her suicide attempt in 2013.
    - Whether Ms Luczak was being monitored as a risk of suicide at the time she died.
    - Whether Ms Luczak was being bullied.

17. The family liaison officer offered to provide Ms Luczak's sister with a copy of the draft report, but she did not wish to receive a copy at this time, or make any comments prior to the publication of this final report.

Background Information

HMP Foston Hall

18. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 310 prisoners in a wide range of categories, including unconvicted and unsentenced women, young adult women under 21 and sentenced women. At the time of the investigation this included 38 women serving life sentences for murder.

19. Derbyshire Health United provides primary healthcare services. There are daily GP sessions on weekdays, with out of hours provision at other times. Three primary care nurses and a healthcare assistant are on duty during the day, reducing to one nurse and a healthcare assistant from 8.00pm to 7.15am. Derbyshire Community Foundation Trust provides mental health provision. The prison runs the CAMEO programme, a specialist intervention for women with complex needs and personality disorders.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Foston Hall was in October 2014. The Inspectorate found that Foston Hall did a reasonable job in managing its population and there was good support for the many women vulnerable to self-harm. Inspectors noted that the number of reported violent or anti-social incidents was not excessive and most consisted of relatively minor disputes and misunderstandings, such as name-calling and relationship issues. Inspectors considered that the prison's approach to managing relationships between women was appropriate. Support for women with substance misuse issues was mainly good.

21. Health provision was generally good. There was a high demand for mental health provision and most needs were being met, although primary mental health services needed to improve. Inspectors noted that it was difficult for officers to supervise the administration of medication, as there were two simultaneous queues at the medicine hatches and the space was crowded and cramped. Women reported there were problems with diverted prescribed medications. Security arrangements were proportionate but the positive mandatory drug-testing rate was higher than at comparator prisons.

22. Some good offender behaviour programmes were offered and inspectors found that the CAMEO Unit on A Wing gave women with personality disorders an excellent opportunity to address their risks.

Independent Monitoring Board

23. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to November 2014, the IMB commented that Foston Hall was a well-run prison where staff endeavoured to provide a fair and decent service in a challenging environment. The IMB noted that local procedures for responding to bullying and anti-social behaviour were well established.

24. The IMB was concerned about the number of complaints received from prisoners about the quality of healthcare and noted that there were no trained mental healthcare staff to respond to emergencies in the evenings and at weekends. The IMB noted that the latest time for dispensing medication was 5.30pm, which was unsuitable for night medication, particularly for those with mental health problems.

Previous deaths at HMP Foston Hall

25. Since 2009, we have investigated three other deaths at Foston Hall. Two of the women hanged themselves and the other cause of death has not yet been determined. Like Ms Luczak, all three women were serving life sentences for murder. In the previous investigation reports, we made recommendations about the quality of ACCT procedures and attempting resuscitation when it is apparent that the prisoner has already died. These issues arose again in this investigation.

Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

27. On 10 March 2012, Ms Magdalena Luczak and her partner were remanded to prison for the murder of Ms Luczak's son. Ms Luczak was taken to HMP Peterborough. She had never been in prison before. The case had attracted significant media attention. Ms Luczak had been monitored as a risk of suicide while she was in police custody and prison staff began ACCT procedures when she arrived at Peterborough.

28. On 13 March, Ms Luczak was transferred to HMP Foston Hall. This first period of ACCT monitoring ended on 24 March. In 2012, staff managed Ms Luczak using ACCT procedures three further times when she was considered at increased risk of suicide and self-harm: from 29 until 30 March, because she was extremely low in mood and tearful; from 5 until 12 September, because she was having active suicidal thoughts; and from 1 until 2 October, because she said she would kill herself after learning the likely length of her sentence and that she was unlikely to regain custody of her children.

29. Throughout her time in prison, Ms Luczak feared other women might attack her because of her offence. In June, officers moved other prisoners who were bullying her. In December, officers challenged other prisoners who threatened Ms Luczak.

30. Ms Luczak was prescribed an antidepressant soon after she arrived at Foston Hall. In July, a prison GP referred her to the mental health in-reach team who supported her from September. A consultant psychiatrist thought Ms Luczak was at high risk of suicide but did not have a major depressive disorder. He prescribed anti-psychotic medication to help her sleep, reduce her anxiety, improve the effect of her antidepressant and treat hallucinations. A mental health nurse and an occupational therapist worked with Ms Luczak.

2013

31. Staff began ACCT procedures for a fifth time from 14 February until 8 March 2013. Ms Luczak's partner had pleaded not guilty, which meant there would be a trial; her two children had been fostered before being adopted; and she learnt in court that her partner had sexually abused her children. In February, Ms Luczak referred herself to the substance misuse team because she was misusing drugs.

32. On 24 April, staff began a sixth period of ACCT monitoring that would last for eight months. Ms Luczak was scared of seeing her (now) former partner at the trial and was devastated by her children's adoption. She told staff that she would kill herself if she lost her children and was found guilty. Ms Luczak's father died in early May and staff constantly supervised her for a brief period.

33. Ms Luczak and her former partner stood trial at Crown Court from late May. Prison staff reviewed her risk of suicide and self-harm when she returned from court each day. On 31 July, Ms Luczak and her former partner were each convicted of murder. On 2 August, she was sentenced to life imprisonment with a minimum period to serve of 30 years before she could be considered for release on life licence. When she returned from court, staff constantly supervised her until 5 August because of her risk of suicide and for her own protection, as her court case had attracted a lot

of publicity and press vilification. Later that month, a prisoner threatened Ms Luczak. Staff warned the other prisoner and monitored both women for a short time.

34. Ms Luczak was reported to have had relationships with other women while she was at Foston Hall. She had shared a cell with another woman during her trial and officers became concerned that their relationship was inappropriate. On 6 September, managers decided to separate them and Ms Luczak tried to hang herself that day. She was taken to hospital and returned to prison on 9 September. Ms Luczak claimed she had been drunk and had had a vision of her deceased father. From 9 September until 30 September, she was constantly supervised in an observation cell in the segregation unit.

35. On 25 September, the psychiatrist discharged Ms Luczak from the care of the in-reach team. He thought that she had symptoms of anxiety and depression, antisocial personality disorder and was suffering from adjustment reaction (a temporary psychotic state, which occurs when the individual is affected by outside events). He concluded that her risk of suicide would remain high while she was in prison, but that she did not require further input from the in-reach team (which usually deals with severe and enduring mental illness). Ms Luczak remained under the care of the GP.

36. During the autumn, staff monitored Ms Luczak using victim support procedures in addition to ACCT procedures because of the media attention and threats from other prisoners. Ms Luczak had her final appointment with a nurse from the in-reach team on 12 November. On 14 December, staff ended victim support procedures because there was no evidence of further threats from other prisoners. On 20 December, they ended the sixth period of ACCT monitoring.

2014

37. In February 2014, staff investigated an allegation that a prisoner had bullied Ms Luczak, but did not find any evidence. Ms Luczak moved to B Wing the same month. In March, prisoners told staff that Ms Luczak was being bullied by a prisoner who was known to have a particular dislike of prisoners who had harmed children. Ms Luczak told officers that she did not want the matter investigated.

38. In April, Ms Luczak's children's social worker informed her that her children were in the process of being adopted. Ms Luczak was allowed to write them one letter a year. Ms Luczak's offender supervisor was aware of the situation and Ms Luczak was only allowed to look at photos of her children in the Offender Management Unit to avoid the possibility of other prisoners learning and publicising their identities.

39. Prison staff used ACCT procedures again for a seventh time between 21 May and 6 June because Ms Luczak was low in mood and had made scratches to her stomach. In the summer, officers noticed that Ms Luczak spent a lot of time with a prisoner who they thought was negatively influencing her. The other prisoner was later moved to a different wing.

40. In July, Ms Luczak asked a probation officer and her offender supervisor to refer her to the Primrose Service at HMP Low Newton, for high risk women with severe personality disorders. The Primrose Service added her to their waiting list, pending

an assessment. As the service offers only 12 places, and prioritises women nearer the end of their sentence, the offender supervisor told Ms Luczak that it was likely that she would have to wait some time.

41. The offender supervisor encouraged Ms Luczak to find ways of settling and coping at Foston Hall. Because of the small number of women's prisons and Ms Luczak's notoriety she thought that, if she transferred to another prison, prisoners would soon discover her offence and it would be difficult to have to start establishing herself at a new prison. She offered Ms Luczak four sessions to explore her feelings about her offence and they met on 17, 24 and 31 July and 7 August. She said that Ms Luczak mentioned that she had made suicide attempts before she had come to prison and was very open and took responsibility for her offence.

42. Staff began an eighth period of ACCT monitoring from 31 July which lasted until 22 October. Ms Luczak was upset after discussing her offence with her offender supervisor and seeing her offence on the television news. She said that she felt like killing herself every day. In August, Ms Luczak's children were adopted. The same month, she was upset when the prisoner who had previously bullied her arrived on B Wing. She felt low because of the notoriety of her offence and the anniversary of her sentencing and told staff that she would have killed herself if she had not been monitored under ACCT procedures. A SO referred her to the mental health in-reach team.

43. In September, the mental health in-reach team began working with Ms Luczak again. She was not sleeping, was anxious and thought others were talking about her. The psychiatrist diagnosed adjustment reaction again and referred her for cognitive behavioural therapy with the occupational therapist. Ms Luczak told the occupational therapist that she had flashbacks of her dead son and that she constantly felt paranoid and anxious. A consultant clinical psychologist attached to the in-reach team saw Ms Luczak to help her develop coping strategies, but she did not engage well.

44. In September, wing staff referred Ms Luczak to the substance misuse team because they suspected she was using drugs. Ms Luczak told a substance misuse worker that she used drugs to cope. She said she did not feel ready to engage with the substance misuse team.

45. On 25 September, the offender supervisor referred Ms Luczak to the Thinking Skills Programme which encourages offenders to change the way they think to avoid offending behaviour. Ms Luczak was not accepted because she was near the start of her sentence, her offence was not compatible with a group work setting and her lack of previous convictions. On 6 October, the offender supervisor referred Ms Luczak to the CAMEO personality disorder service. The CAMEO team did not process the referral or reply to her and the referral was not pursued further.

46. On 7 October, staff planned to move Ms Luczak away from a prisoner who she was not getting on with. Ms Luczak cut herself and said she would kill herself if she was moved. On 8 October, the psychiatrist reviewed Ms Luczak and the move was cancelled as it was thought it would be detrimental to her mental health. On 9 October, the occupational therapist saw Ms Luczak and decided not to offer her any further sessions as her depression could be managed by the primary care GP.

47. Around this time, Ms Luczak socialised a lot with two other prisoners. Officers saw one prisoner as a positive influence but were surprised by her friendship with the other, who had previously bullied Ms Luczak.

48. On 22 October, the eighth period of ACCT monitoring ended and the psychologist reviewed Ms Luczak. On 12 November, Ms Luczak told the psychiatrist that she felt paranoid, angry, low, and stressed. She said she did not have any suicidal thoughts, but would not tell him even if she had, as officers would then begin ACCT procedures again.

49. On 19 November, other prisoners accused Ms Luczak of trying to harm a prisoner by giving her rat poison. This was never proven. Staff began ACCT procedures for the ninth period and investigated the behaviour of seven women, who had made the allegations. Three women were moved to different wings. Ms Luczak and this prisoner stayed on the wing, officers mediated between them and they agreed to be friends. On 24 November, officers found a 'goodbye letter' written by Ms Luczak in Polish.

50. On 26 November, the offender supervisor had an annual sentence planning review with Ms Luczak. They added goals to her sentence plan, including education, dealing with substance misuse and pursuing the possibility of the Primrose Service. Staff ended the ninth period of ACCT monitoring on 3 December. On 9 December, Ms Luczak heard that her appeal for a reduction in the minimum time she had to serve had failed. Staff began ACCT procedures for the tenth time, which continued until 16 December.

51. On 10 December, Ms Luczak told the psychiatrist that she had seriously considered suicide by hanging and had written a note but had not been able to go through with it. Ms Luczak did not think that her antidepressant medication was helping and they agreed to reduce it. He reviewed Ms Luczak again on 24 December, diagnosed a relapse of depressive disorder and increased her antidepressant medication.

2015

52. On 7 January 2015, Ms Luczak told the psychiatrist that she sometimes felt tired of living. She felt that her antidepressant medication was helping. On 18 January, Ms Luczak moved to B Wing. On 22 January, a doctor saw Ms Luczak at a GP surgery. Ms Luczak was suffering from stress, anxiety and migraines and was smoking heavily.

53. The offender supervisor saw Ms Luczak on 3 March, which was the anniversary of her son's death. Ms Luczak said she wanted to transfer to HMP Send to join an addiction treatment programme run by RAPt (the Rehabilitation for Addicted Prisoners Trust). Ms Luczak planned to write to her adopted children at the next opportunity in October. Ms Luczak's friend was about to transfer to another prison and the offender supervisor was concerned that this might leave her isolated.

54. On 18 March, the psychiatrist saw Ms Luczak and noted she had low mood and energy, was neglecting her appearance, had poor sleep and appetite and had lost interest in activities. She was having erratic mood swings. Ms Luczak again told him that she would not say if she was having suicidal thoughts. He prescribed a different antidepressant and asked the psychologist to see Ms Luczak again.

55. On 23 March, Ms Luczak told the substance misuse worker that she had been using illicitly obtained subutex (an opiate substitute) because she was depressed and struggling to cope. She said that she kept relapsing into drug misuse for short-term relief from her circumstances. The substance misuse worker and the offender supervisor referred her to the RAPt programme, which they thought she should complete as a priority.

56. On 8 April, the psychologist saw Ms Luczak, but Ms Luczak told her that she did not feel that psychological treatment would help. On 17 April, she told the substance misuse worker that she was still using subutex and, on 24 April, said she was using six to eight lines of subutex a day and was trading her belongings to pay for it. She said subutex was her way of coping without cutting herself. She said she was desperate for help and the substance misuse worker referred her to a doctor. On 29 April, the psychologist saw Ms Luczak for another session, where she also mentioned her subutex misuse.

57. On 30 April, Ms Luczak had a urine test ordered by the GP and was positive for subutex. She said she was seeking out subutex all over the prison and used it every day. On 5 May, she told a doctor that she had used subutex as a means of coping since she had first arrived in prison but had only recently become dependent. The doctor prescribed methadone increasing to 15mls, then a maximum of four weeks maintenance, followed by a reduction of 5mls a week for three weeks before concluding treatment. The doctor reviewed Ms Luczak on 12 May and she said she was feeling better.

58. On 13 May, Ms Luczak missed an appointment with the psychologist. The psychiatrist saw her the same day and concluded that her anxiety and depression were in remission. He did not think that she had a serious mental health problem for which she needed the help of the in-reach team and he discharged her. He advised the GP that Ms Luczak should be prescribed an antidepressant for at least another year.

59. On 2 June, the RAPt team at Send told the substance misuse worker that they would not accept Ms Luczak because it was too early in her sentence, but promised to reconsider in 12 months. She was concerned that this news would destabilise Ms Luczak. She spoke to the offender supervisor, who agreed to look for an alternative transfer. On 5 June, Ms Luczak told the substance misuse worker that she was anxious about how she would cope when her methadone was reduced and eventually stopped.

60. On 10 June, a doctor reduced Ms Luczak's methadone to 10ml daily and the substance misuse worker told her about the RAPt team's decision. Ms Luczak missed another appointment with the psychologist. On 11 June, the security department received information that Ms Luczak might be having a relationship with a prisoner. On 12 June, Ms Luczak told officers that her former partner had photos of her children and they alerted the security department at his prison. On 17 June, Ms Luczak's methadone was reduced to 5ml daily. She was supposed to complete her treatment a week later, but decided to stop on 18 June.

61. On 19 June, Ms Luczak complained to her offender supervisor that she was unable to make telephone calls to her mother in Poland. Ms Luczak was subject to public protection restrictions and all telephone numbers had to be approved by the

Offender Management Unit. Ms Luczak said that staff had been unable to obtain the necessary permission from her mother because she only spoke Polish, but our investigation found no evidence of an outstanding application from Ms Luczak to add her mother to her approved telephone list. Only one telephone number, designated 'Home – Poland', had ever been approved and this was added to her foreign national telephone account in 2012. It is unclear whether this number was her mother's or whether it was no longer current.

62. As a foreign national prisoner, Ms Luczak was entitled to a free five-minute telephone call abroad to this number every month. Accordingly, she had been receiving monthly credits of £1.78, but these had accumulated and she had never used them. Following Ms Luczak's complaint, her offender supervisor made enquiries and located a Polish speaking member of staff at HMP Nottingham who could telephone Ms Luczak's mother and check that she was prepared to accept calls from her. However, no action was taken before she died.

63. The offender supervisor told the investigator that Ms Luczak had been hostile and angry on 19 June. She said she was sick of being at Foston Hall and wanted to move to another prison. The offender supervisor told her that a forensic psychological assessment in July or August would help them to plan for the next stage of her sentence and a possible transfer.

64. The same day, 19 June, Ms Luczak cut her arm and an officer began ACCT procedures for the eleventh time. She said she did not want to talk to officers because they were all liars. A SO completed an ACCT immediate action plan and set hourly observations until the first case review. A nurse examined and treated Ms Luczak; she asked for treatment for symptoms of drug withdrawal. Ms Luczak had made multiple cuts to her abdomen so a nurse referred her to the primary mental health team.

65. On Saturday 20 June, an officer went to assess Ms Luczak as part of the ACCT process, but Ms Luczak ignored her and stared out of the window. She seemed very angry and told her that there was no point in speaking to her. The officer told Ms Luczak that she was not obliged to stay and Ms Luczak walked out.

66. A SO and an officer then held the first ACCT case review with Ms Luczak. The SO told the investigator that she had arranged for a nurse to attend, but Ms Luczak said she would not stay if there were any healthcare staff present. She was annoyed that nurses would not change the dressing for her cut until the next day. The officer had planned to attend the case review, but the SO felt that this might be counterproductive.

67. At the ACCT review, Ms Luczak was angry and initially refused to engage but she slowly opened up. She was upset because she did not think she had been paid correctly for her work as a wing cleaner. Ms Luczak said she was not having any thoughts of harming herself but she would not make eye contact. The SO was not confident about Ms Luczak's assurances and remembered her attempt to hang herself in 2013. The review assessed her risk of suicide and self-harm as raised and decided that staff should check Mrs Luczak three times an hour when she was locked in her cell and once an hour when she was unlocked. They were also required to record one conversation with her each day. The SO noted that a

member of the mental health in-reach team and a general nurse should attend the next (multidisciplinary) case review on 22 June.

68. The SO recorded three issues on the ACCT care map: Ms Luczak's refusal to engage with staff, an application to the activities department about her pay, and an application to the Offender Management Unit about her telephone numbers. Ms Luczak was given joint responsibility with her personal officer for addressing the first issue and sole responsibility for making the applications.

69. On 22 June, a SO and the B Wing manager held the second ACCT case review with telephone contributions from a nurse, a member of the in-reach team and a member of the Offender Management Unit. The nurse advised that Ms Luczak had recently self-harmed and was struggling after finishing her methadone treatment. The in-reach team member said that the in-reach team was no longer working with Ms Luczak.

70. Ms Luczak said she did not want to be referred back to the mental health in-reach team. The SO and the B wing manager were unaware that a nurse had recently referred Ms Luczak to the primary mental health team. They did not add mental health as an issue to the care map. The review checked that Ms Luczak was due to see her offender supervisor on 30 June, which would be an opportunity to sort out her phone numbers. The manager spoke to the activities department about Ms Luczak's pay and the SO marked the three existing issues on the care map as complete. Ms Luczak said that she had started misusing subutex again but the SO did not add this as a new issue for the care map.

71. The review continued to regard Ms Luczak as at raised risk of suicide and self-harm but changed the frequency of observations to two checks every hour when Ms Luczak was locked up and once an hour when she was unlocked. Staff were required to have and record two conversations with Ms Luczak each day. The third ACCT case review was scheduled for 30 June, after Ms Luczak had seen her offender supervisor. On 23 June, earnings of £25.20 were credited to Ms Luczak's account, apparently correcting the mistake with her wages. That day, the regular Support and Intervention meeting noted that Ms Luczak might be having a relationship with another prisoner.

72. On 25 June, Ms Luczak told the substance misuse worker that she was unhappy, not sleeping or eating and did not feel well. She said she was abstaining from illicit drugs. Ms Luczak was unhappy about the RAPt team's decision. The substance misuse worker explained that this decision could be revisited in a year, but Ms Luczak was not interested in this.

73. On 26 June, Ms Luczak did not attend a planned primary care mental health assessment. On 29 June, she tested positive for benzodiazepines. She said she was taking illicit diazepam (a benzodiazepine) to help her sleep and was finding it difficult not to take subutex. A nurse referred her to a doctor in the primary mental health team and the substance misuse worker.

74. At 10.00am on 30 June, the offender supervisor saw Ms Luczak and thought that she was calmer than on 19 June but was quite low, on edge, and was not coping very well. They discussed her forthcoming forensic psychological assessment in late July or August, her sentence plan and possible transfer. Ms Luczak said that

her only regular visitor was planning to return to Poland. She was worried about becoming further isolated and not being able to speak Polish to anyone. The offender supervisor told her that she was arranging for public protection checks so her mother's telephone number could be approved. Ms Luczak talked about her annual contact with her children due in October and looked at the photos of them, which were held in the Offender Management Unit. She smiled and talked fondly about them. The offender supervisor had no serious concerns about Ms Luczak and did not consider she was at risk of suicide or self-harm at the time.

75. At 2.00pm the same day, a SO and an officer held the third ACCT case review. The offender supervisor contributed by telephone beforehand. Ms Luczak appeared brighter. She said that the photos of her children had upset her a little, but the SO thought she seemed OK. Ms Luczak would not say if she was taking drugs and the SO concluded that she probably was. She would not say if she was in debt for drugs. The SO did not add substance misuse problems as an issue for the care map, but submitted an intelligence report to the security department outlining her suspicions that Ms Luczak was using illicit substances.

76. The SO added a fourth issue to the ACCT care map, for Ms Luczak to re-engage with the chaplaincy. She then emailed them and marked the action as complete. The SO told the investigator that Ms Luczak said she was happy for the ACCT to be closed and no longer felt she needed support. The review assessed her risk of suicide and self-harm as low and ended ACCT procedures.

77. After the case review, a doctor and the substance misuse worker reviewed Ms Luczak because she had tested positive for benzodiazepines. She said she had started taking diazepam during her methadone treatment to help her sleep. They discussed her risk of suicide and Ms Luczak said that she would not kill herself for at least eight years, until her eldest child turned 18 and could visit her unsupervised. The doctor thought that Ms Luczak needed to examine the underlying reasons for her drug misuse. She telephoned the mental health in-reach team manager and asked whether the team could consider working with her again.

78. On 1 July, the mental health in-reach team discussed Ms Luczak at a multidisciplinary meeting. The psychiatrist did not think that she would benefit from further input from the in-reach team because she no longer had an adjustment reaction that required their help. He thought that the only treatment that might help was the psychological approach, but this required Ms Luczak to engage and she had repeatedly missed appointments. The team decided not to accept Ms Luczak back onto their caseload.

79. On 7 July, a nurse completed a primary care mental health assessment with Ms Luczak. She seemed a little low in mood and said she had been using subutex for the past few days and diazepam before that. Ms Luczak said she wanted to complete her forensic psychological assessment, move prisons for a fresh start and start addressing the reasons for her offending. The nurse diagnosed depression, anxiety and trauma. He considered that Ms Luczak should continue to work with the psychologist, the Offender Management Unit and the substance misuse team, but he did not think that she needed the support of primary mental health services.

80. Later that day, the substance misuse worker told Ms Luczak that the in-reach team had decided not to accept her on their caseload. Ms Luczak said that she had

expected this. She said that she was now taking diazepam rather than subutex. The substance misuse worker thought that Ms Luczak seemed brighter and planned to see her again on 14 July.

81. On 8 July, a SO saw Ms Luczak for an ACCT post-closure review. She noted that Ms Luczak's mood was good and she had resolved the problem with her pay. She said that she had still not been able to telephone her mother but the Offender Management Unit was trying to arrange this. She was looking forward to her friend visiting on Sunday 12 July. They spoke about the approaching anniversary of Ms Luczak's son's birthday on 15 July. Ms Luczak said that this would upset her but that she would be OK. Afterwards, the SO recorded the anniversary in the B Wing observation book and wrote that although Ms Luczak might be upset by this, she had no thoughts of harming himself.

82. That day, 8 July, Ms Luczak did not attend a third consecutive appointment with the psychologist. The psychologist therefore discharged her from her caseload. Also on 8 July, the weekly safer custody meeting decided to move Ms Luczak to another wing to break up a relationship she was apparently having with another prisoner. On 9 July, the Quaker chaplain saw Ms Luczak in her cell with her friend. They prayed together. Ms Luczak had been feeling down but seemed brighter afterwards. Ms Luczak talked about her son's birthday and the chaplain arranged to light a candle with the two women in the chapel on 15 July.

83. On Sunday 12 July, Ms Luczak had a visit from her friend who was planning to go back to live in Poland. Afterwards, an officer found her crying in her cell when he came to lock her up for the night at about 5.15pm. He offered to talk but she was upset and told him to get out. He locked Ms Luczak in her cell and left her alone for half an hour. When he went back, she nodded when he asked her if she was OK and shook her head when he asked if she wanted to talk. He concluded that she was just upset because her visitor had left. He was on duty until 9.00pm and said he checked Ms Luczak three or four more times that evening as a precaution. She was asleep when he left.

84. On Monday 13 July, Ms Luczak completed her usual duties as a wing cleaner. Two prisoners said that they spent much of the day with Ms Luczak. They said that she had been really upset about a prisoner with whom she had been having a relationship. (This prisoner told the investigator that their relationship had recently ended. Neither woman had told staff about their relationship, although Ms Luczak's personal officer said she had suspected it.) Both prisoners recalled that Ms Luczak had said that if she did not get away from this prisoner, she would be leaving the prison in a body bag. She said that her relationship with her reminded her of her relationship with her former partner. Her friends said that Ms Luczak seemed to be at an all-time low but they believed that they had managed to calm her down and cheer her up. The investigator interviewed five prisoners who lived on B Wing, including the prisoner. Several said that she had talked about leaving the prison in a box in the days before she died, but we found no evidence that anyone told staff that she might be having suicidal thoughts.

85. In the late afternoon, Ms Luczak went to the wing servery but did not collect a meal to take back to her cell. A prisoner said that Ms Luczak seemed fine and was joking when she was locked up for the night at about 4.45pm. (Prisoners did not have their usual time out of their cells during the early evening because a number of

officers were involved in hospital escorts.) Later, women were unlocked briefly to collect their medication, but Ms Luczak did not collect her antidepressants. Ms Luczak and the prisoner she had had a relationship with had cells next to each other and other prisoners heard them having a heated argument out of their windows during the evening.

86. The B Wing night patrol officer on the night of 13/14 July did roll counts at 9.00pm, 1.00am and 6.00am to check that prisoners were present in their cells. During the 1.00am check, she said she saw Ms Luczak sleeping on her bed. At the 6.00am check, Ms Luczak was not in bed and the light was on in the shower room, ensuite to the cell. She assumed that Ms Luczak was in the shower room getting ready. She said a prisoner on the second landing then pressed her cell bell and she went to check what she wanted, without getting a response from Ms Luczak.

87. At about 7.05am, Officer A arrived on B Wing. The night patrol officer handed over to him and did not pass on any concerns. He started a roll count. When he reached Ms Luczak's cell, he knocked on the door several times, called her name and kicked her door, but got no response. The shower room light was still on.

88. Officer A went to the B Wing office and told the night patrol officer that he could not get a response from Ms Luczak, that he was going into the cell and that he needed more officers. He asked her to join him, as he was reluctant to go into the cell alone in case Ms Luczak was showering. The night patrol officer radioed to ask for staff assistance on B Wing.

89. At Ms Luczak's cell, Officer B called her name, told her he was coming in and unlocked the door. When he went in, he found that Ms Luczak had hanged herself from the shower mixer tap using a belt. Ms Luczak was suspended above the floor and was wearing her day clothes.

90. At 7.12am, the night patrol officer radioed to control room staff, 'Medical assistance required on Bravo Wing Room 17 – code blue'. (Code blue is the correct emergency response code, which should prompt control room staff to call an ambulance immediately.)

91. Officer B supported Ms Luczak's weight while the night patrol officer removed the belt manually from the shower fitting. (She did not have a cut-down tool that uniformed officers should usually carry.) They lowered Ms Luczak to the floor and the officer began to attempt cardiopulmonary resuscitation by chest compressions and rescue breaths. Another officer arrived and took over chest compressions, while Officer A gave breaths.

92. The emergency took place just as the night staff were leaving the prison. A SO, who had been the night orderly officer in charge of the prison, was at the gate and had already handed her radio and keys in so an officer took her to B Wing. The orderly officer for the day followed. The SO took the night patrol officer from the cell, as she was in shock, and asked an officer to radio for an ambulance. At 7.15am, control room staff called the ambulance service.

93. The first member of healthcare staff to arrive in the cell brought an emergency response bag and oxygen. The two officers continued resuscitation while the nurse unpacked the emergency equipment. Two more nurses arrived and the staff moved

Ms Luczak into the main part of the cell where there was more space. A nurse took over chest compressions. She told the investigator that she knew from Ms Luczak's appearance that she had been dead for some time. However, she decided to proceed with resuscitation.

94. There was no bag-valve-mask in the emergency bag, so a healthcare assistant gave oxygen temporarily using a re-breath mask until a nurse brought a spare bag-valve-mask. The re-breath mask is only effective if the patient is breathing, so the nurses switched immediately to the bag-valve-mask. The nurses attached a defibrillator but it found no shockable heart rhythm and advised them not to deliver a shock.

95. At 7.25am, an ambulance arrived at the prison gate. Paramedics arrived at Ms Luczak's cell on B Wing at 7.34am. They identified partial rigor mortis and pronounced Ms Luczak dead at 7.35am.

Contact with Ms Luczak's family

96. An SO, a trained family liaison officer, came into the prison at 10.30am. Ms Luczak had named her sister as her next of kin and had given two different addresses. There had been no recent contact between them and it appeared that Ms Luczak's sister was no longer living at either address. The police traced Ms Luczak's sister at 1.30pm. The Governor and the SO left the prison at 2.00pm and arrived at Ms Luczak's sister's home at 4.00pm. Ms Luczak's mother was also there. Two police family liaison officers, who had worked with her family during her trial, accompanied them. They informed Ms Luczak's family that Ms Luczak had died, offered condolences and support. The prison arranged and paid for Ms Luczak's funeral, In line with Prison Service instructions. The SO, as well as a prison manager, the prison's Roman Catholic chaplain and a friend of Ms Luczak, attended.

Support for prisoners and staff

97. At 8.15am on 14 July, the Governor debriefed the staff involved in the emergency response and offered her support and that of the staff care team. At 9.00am, the Governor asked members of the chaplaincy team to visit the wings to support the prisoners. Staff reviewed all women assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Luczak's death.

Post-mortem report

98. The post-mortem examination identified the cause of death as hanging. The toxicology tests found no evidence of subutex or other illicitly obtained medication.

Findings

Assessment and management of Ms Luczak's risk

99. The psychiatrist considered that Ms Luczak was a risk of suicide throughout her sentence, because of the nature of her offence, her lengthy sentence, the loss of her children, her use of illegal substances and her social isolation. Although Ms Luczak was always at risk, ACCT procedures are intended to manage prisoners in crisis and are not designed to be used indefinitely.

100. We consider that overall, Foston Hall began monitoring procedures appropriately, at times when they identified Ms Luczak as at increased risk. During Ms Luczak's three years at Foston Hall, we found that officers and healthcare staff knew about her risks and triggers. In particular, her offender supervisor, personal officer, GP, psychiatrist and substance misuse worker all had good insight into Ms Luczak's problems and were committed to supporting her. In September 2013, she very nearly killed herself by hanging, but was saved by an effective emergency response by prison staff.

101. After her last period of ACCT monitoring ended on 30 June, there were a number of issues that possibly increased Ms Luczak's risk of suicide during July. We accept that these are easier to spot with hindsight. Ms Luczak was disappointed at not being accepted on the RAPt programme; she had had a visit from a friend who was very soon returning to Poland; we were told a television programme about women prisoners which might have mentioned Ms Luczak's offence was transmitted on 13 July (although we found no evidence of this); she had apparently just come out of a relationship with another prisoner and on the evening before her death had argued with her; it is possible that Ms Luczak was suffering from opiate withdrawal symptoms as no subutex was found in post-mortem toxicology tests; and 15 July was the birthday of her son, the victim of her offence.

102. In a thematic report about risk factors in self-inflicted deaths published in April 2014, we noted that the level of risk is not fixed and stressful events can have a sudden and critical impact. Staff need to be vigilant for any changes that might indicate increased risk. However, we recognise that spotting these changes is particularly difficult with a prisoner like Ms Luczak, who was always at long-term risk of suicide.

103. It is a particular challenge to keep hope alive for prisoners, like Ms Luczak, who have many years of their life ahead of them in prison before they have any prospect of release. Ms Luczak's offender supervisor tried to keep her motivated by referring her to relevant interventions and offending behaviour programmes, but these are targeted at prisoners who are closer to release. While this is understandable, there is a wider strategic issue about how to keep prisoners serving increasingly long indeterminate sentences motivated, if they do not have access to such interventions early in their sentence. This is a particular issue for women prisoners, as the options are even more limited than for men.

104. Overall, although we had some concerns about the operation of ACCT procedures, which we set out below, we consider that Ms Luczak was appropriately supported at Foston Hall, within the constraints of the prison. Just before her death, there was

no immediately obvious reason why staff should have identified her as at high or imminent risk of suicide.

Management of ACCT procedures

105. Ms Luczak was supported by ACCT procedures for 11 separate periods in three years. Overall, her ongoing risk of suicide was well monitored but some periods of ACCT monitoring were for only a very short time, lasting only one or two days, which was unsatisfactory given the serious concerns that had led to the monitoring in the first place. In 2013, when officers monitored Ms Luczak before, during and after her trial, ACCT procedures were effectively managed and she was well supported.

106. However, we do not consider that the last period of ACCT monitoring and support, between 19 June (after Ms Luczak cut herself) and 30 June, was managed fully effectively.

107. A nurse referred Ms Luczak for a primary mental health assessment on 19 June, but did not record this in the ACCT document. Prison Service Instruction (PSI) 64/2011 (Safer Custody) requires a member of healthcare staff to attend the first ACCT case review. At Ms Luczak's insistence, there were no healthcare staff present at the review on 20 June. The case manager felt that involving a nurse would be counterproductive.

108. We accept that this was a pragmatic approach, but this risked issues about Ms Luczak's mental health being missed. In the absence of healthcare staff, extra efforts should have been made to seek healthcare views about Mr Luczak's risks and concerns but this did not happen. The case review was unaware that a nurse had referred Ms Luczak for a mental health review the day before and the SO did not record mental health as an issue on the care map.

109. The SO noted that there should be a multidisciplinary review two days later, with relevant healthcare staff attending. In the event, healthcare staff made remote contributions rather than attending in person. This hampered effective discussion of relevant issues at the case review. At the second case review, mental health was still not identified as an issue for the care map.

110. There was no contribution or attendance from healthcare or substance misuse staff at the third and final case review. Ms Luczak was upset about being turned down for the RAPt course at Send, but there is no evidence that this was discussed during the ACCT process. A SO, who had not been trained in ACCT case management, was unaware that Ms Luczak had a referral for a mental health assessment which was still outstanding. Although the SO believed that Ms Luczak was using illicit drugs, she did not add substance misuse to the care map as an issue to be addressed, yet she had identified this as a security issue. The SO added a care map action for Ms Luczak to re-engage with the chaplaincy and marked the action as complete, although all she had done was to refer Ms Luczak. The issue of Ms Luczak's telephone contact with her mother was never satisfactorily resolved.

111. There is no evidence that Ms Luczak had active or imminent thoughts of suicide at the time ACCT procedures ended on 30 June, and the weaknesses in the process

which we have identified are mainly procedural. However, we do not consider that the ACCT caremap was used effectively to identify and address the key issues and ACCT monitoring should not have ended until all care map actions had been fully completed. We are concerned about the lack of multidisciplinary involvement in ACCT reviews for a complex case involving a woman who was always at long-term risk of suicide. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular that:

- **There is a multidisciplinary approach for all case reviews, with healthcare staff attending all first case reviews and subsequent reviews where relevant.**
- **ACCT caremap actions are specific and meaningful, address all of the issues identified during the assessment interview and case reviews and that ACCTs are not closed until all caremap actions have been completed.**
- **All staff, including healthcare staff, record relevant information about risk, observations, and interactions with prisoners in ACCT documents, and any action taken.**
- **Case managers have relevant training.**

Ms Luczak's relationships with other prisoners

112. Foston Hall's decency policy states that sexual relationships will be treated as unacceptable behaviour and that prisoners might be separated if staff have evidence of a relationship. Information recorded by the security department and entries in Ms Luczak's prison record show that she was suspected of having relationships with a number of women at Foston Hall. Ms Luczak appears to have had relationships with more dominant women who could offer her protection and supply her with drugs. Staff recognised that this was not healthy and, in 2013, managers identified a relationship and separated the prisoners. This led to Ms Luczak's first, serious suicide attempt.

113. Ms Luczak became very close to a particular prisoner in the months before she died. This prisoner was well known to dislike prisoners who had harmed children, and had previously bullied Ms Luczak. Officers knew that this prisoner tended to form relationships with women she could easily dominate. Very soon after Ms Luczak died, this prisoner was transferred to another prison for drug dealing and had possibly been supplying drugs to Ms Luczak.

114. Ms Luczak's personal officer had suspected that Ms Luczak and the prisoner were in a relationship, as they spent a lot of time together. With the amount of intelligence about the prisoner and the likely influence she would have had over Ms Luczak, we consider that officers should have challenged their close association, whether or not it was sexual. There is nothing in Ms Luczak's prison record or security reports to indicate that officers had any concerns.

115. On 11 June, the security department received information suggesting that Ms Luczak might be having a relationship with another prisoner. The safer custody

team discussed Ms Luczak's possible relationship with another prisoner at their meeting on 23 June. At another safer custody meeting on 8 July, staff identified the other prisoner. Staff planned to move Ms Luczak to a new wing, but did not do so before 14 July.

116. In our investigation into the death of a woman at Foston Hall in 2009, we also found that staff failed to challenge an inappropriate relationship between two women. We make the following recommendation:

The Governor should ensure that staff challenge prisoners in line with the local decency policy if there are justified concerns that their relationship is detrimental to the wellbeing of one of the women.

Clinical care

117. Ms Luczak was twice under the care of the in-reach team but her psychiatrist discharged her in May 2015 as he did not think that they could offer any further useful treatment. At the beginning of July, a prison GP asked the in-reach team to consider again whether there was anything they could offer but the in-reach team maintained that Ms Luczak would not benefit from their care. The psychiatrist believed that Ms Luczak's risk of suicide was high and would remain so, but he did not think this was caused by a mental disorder that the in-reach team could treat.

118. In early July, Ms Luczak was referred to the primary mental health team for an assessment after cutting herself. A nurse saw her and did not think that she needed their input and that she could get support from the substance misuse team, the psychologist and her offender supervisor. However, Ms Luczak missed successive appointments with the psychologist, showed no motivation to engage and was discharged from that service on 8 July.

119. The clinical reviewer reviewed Ms Luczak's clinical care. He found that it was good and at least the equivalent of the level of care that could be expected in the community. He considered that the decisions made by the in-reach team were reasonable and were discussed and documented appropriately. He identified no significant faults in the standard of healthcare Ms Luczak received at Foston Hall.

Substance misuse

120. Ms Luczak was dependent on illicit substances in prison. She received good ongoing support from the substance misuse worker and seemed to engage well with her. However, it is concerning that Ms Luczak was apparently able to get access to drugs easily, either diverted from other prisoners' prescribed medication or smuggled into the prison. The easy availability of illicit substances was something HM Inspectorate of Prisons identified as a problem during their most recent inspection of Foston Hall. We make the following recommendation:

The Governor should ensure that there is an effective supply reduction strategy to reduce the availability of illicit drugs and diverted medication.

Emergency response

121. It is apparent that Ms Luczak was dead at the time she was found hanged and could not have been resuscitated. This means that the quality of the emergency response would not have affected the outcome for Ms Luczak. However, there were a number of deficiencies, which could be critical in future emergencies and need to be rectified.

122. The local security strategy for night roll checks requires the night patrol officer to assure themselves that the roll is correct and that each prisoner is in their cell. If they cannot be sure, they must contact the night orderly officer in charge of the prison immediately. The night patrol officer on B Wing on the night of 13/14 July did not see or get a response from Ms Luczak at the 6.00am roll count. As Ms Luczak had partial rigor mortis just over an hour later, it is very likely that she had already hanged herself when the night patrol officer did the roll count. Nevertheless, the night patrol officer should have accounted for Ms Luczak at the time and if she was not able to do so, she should have raised an alarm.

123. PSI 64/2011 requires all uniformed staff to be provided with and carry their own personal issue cut-down tool to remove ligatures when they find a prisoner hanging. The night patrol officer was employed by an agency. Foston Hall requires agency staff to be trained before being issued with a cut-down tool, but the night patrol officer had not had this training before working nights. Contrary to PSI 64/2011, she was not given a cut-down tool.

124. PSI 03/2013 (Medical Emergency Response Codes) requires staff to communicate the nature of a medical emergency using a code system. When control room staff receive an emergency medical code, they should call an ambulance immediately, without waiting for further information. On 10 July 2015, the Governor had issued an information notice to staff about the use of emergency codes. The night patrol officer used the correct emergency code, but there was a three-minute delay before control room staff called an ambulance. The staff waited until a manager reached the scene and specifically requested an ambulance. The PSI makes it clear that it should not be a requirement for a manager or member of the healthcare team to attend an incident before an emergency ambulance is called. While this delay would not have made a difference on this occasion, it could be critical in future emergency responses.

125. Nurses brought an emergency response bag, which was missing the bag valve mask used to give oxygen. A nurse had to run and collect a spare from a different wing. In the meanwhile, staff had to improvise with another type of mask. This did not assist their efforts as it can only be of benefit if the patient is already breathing on their own. Again, the absence of the bag valve mask made no difference on this occasion, but could be critical in future.

126. Nurses continued to perform cardiopulmonary resuscitation even though they were certain that Ms Luczak was dead. When the paramedics arrived, they almost immediately pronounced her dead and questioned the staff's decision to attempt resuscitation. There is no local policy to guide the staff about when they should not attempt resuscitation and nurses have not been trained to recognise the signs of death. This issue previously arose when we investigated the death of a woman in December 2012. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that all prison staff are made aware of their responsibilities under PSI 03/2013 and that in particular:

- **Staff account for every prisoner during roll counts.**
- **All uniformed staff carry an anti-ligature cut-down tool.**
- **Control room staff understand their responsibilities during medical emergencies.**
- **Emergency response bags contain all necessary equipment.**
- **Staff are given guidance about the circumstances in which resuscitation is not appropriate.**

Staff support

127. PSI 64/2011 states that staff affected by a death in custody might require support at any time and on more than one occasion. Four members of staff who we interviewed complained about a lack of support from managers. The OSG, who was agency staff, said she had not returned to work since the emergency. It had been the SO's first shift as a night orderly officer and she carried on working for the next six nights. She felt that there was an expectation from managers to carry on and be OK. Ms Luczak's personal officer said that she did not have faith in managers to support her. The SO was the care team leader after the incident, but said she was not offered any support, although she had closed Ms Luczak's most recent ACCT document. At the very least, we found a number of staff who perceived a lack of support. We make the following recommendation:

The Governor should ensure that staff are appropriately supported after the death of a prisoner.

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