Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Levand, a prisoner at HMP Ranby, on 29 June 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.

Mr Levand was found hanged in his cell at HMP Ranby on 29 June 2015. Mr Levand was 45 years old. I offer my condolences to Mr Levand's family and friends.

While I recognise that there was little to indicate that Mr Levand was at heightened risk of suicide in the days immediately before his death, the investigation found weaknesses in the suicide prevention procedures at Ranby. There was also too little investigation of his complaints about threats from other prisoners.

Similarly, while I am satisfied that he generally received appropriate support for his significant substance misuse problems, he was clearly badly affected by his rapid detoxification from diazepam, which he had been taking for many years. He was also able to continue using illicit substances, including new psychoactive substances. As I have found in previous investigations into deaths at Ranby, the easy availability of new psychoactive substances is a serious matter that the prison needs to address.

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 **April 2016**

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Summary

Events

1. On 13 October 2014, Mr Mark Levand was remanded to HMP Nottingham charged with handling stolen goods and burglary. It was not his first time in prison. He had a history of substance misuse. Mr Levand began a supervised alcohol withdrawal programme and a methadone maintenance programme, to manage his heroin addiction. He said he had been previously been prescribed diazepam (a benzodiazepine) and had also taken it illicitly for twenty years. A prison GP prescribed a 21-day withdrawal programme in line with the prison's established protocol.

2. On 5 November, Mr Levand cut his neck. He said that the diazepam had been withdrawn too quickly. He was taken to hospital and prison staff managed him, using suicide and self-harm prevention procedures (known as ACCT) for three weeks. A mental health nurse concluded Mr Levand had moderate depression and anxiety, and would benefit from ongoing mental health support.

3. On 27 January 2015, Mr Levand was sentenced to two years and six weeks imprisonment and, on 6 February, he was moved to Ranby. At an initial health screen, he told a nurse that he had taken illicit drugs at Nottingham, the day before. The nurse referred him to the substance misuse clinic. Mr Levand continued his methadone maintenance programme and was supported by a mental health nurse at monthly appointments.

4. On 26 February, Mr Levand told officers that he was having problems with some prisoners in his workshop, who were threatening him for drug debts from the community. Officers asked him to complete a form giving them further information about the threats, but Mr Levand did not return the form. Staff took no further action.

5. On 17 April, Mr Levand cut his neck and his head, after taking a new psychoactive substance (NPS). He was taken to hospital for treatment and a cell search uncovered three other wraps of the drug. When he got back to the prison later that night, staff assessed Mr Levand as at high risk of suicide or self-harm and he was constantly supervised for five days. Staff monitored him under ACCT procedures, until 11 May.

6. On 14 May, Mr Levand's mental health key worker told him that she would no longer be his key worker and someone else from the mental health team would see him. No one from mental health team saw him after that.

7. On 23 May, Mr Levand said he had taken an overdose of paracetamol, but hospital tests showed he had not. Staff monitored him under ACCT procedures until 22 June.

8. At 9.13am on 29 June, an officer found Mr Levand hanged in his cell by a belt attached to the window bars. The officer used a general alarm rather than a medical emergency code to summon help but another officer quickly rectified this and an ambulance was called immediately. Prison staff tried to resuscitate Mr

Levand. Paramedics arrived and continued emergency treatment. At 10.12am, the paramedics recorded that Mr Levand had died.

Findings

9. Mr Levand was assessed as at risk of suicide and self-harm and managed under ACCT procedures twice at Ranby. The records of the first period of ACCT monitoring are missing, which would not have helped assess his risk subsequently. We do not consider that the ACCT procedures from the second period were managed fully effectively. Mr Levand had complex substance misuse, mental health, and physical health needs, but a member of healthcare staff attended only one case review. There was no consistent case manager. Mr Levand's mental health key worker was reallocated in May, just before he was assessed as at risk of suicide and self-harm for the last time and he did not receive any further mental health support.

10. Prison staff did not investigate further when Mr Levand told them that other prisoners were threatening him. There is no record that staff considered whether his anxieties about threats and intimidation affected his risk of suicide and self-harm.

11. Mr Levand admitted using illicit drugs, including new psychoactive substances, at Ranby and it is possible that the use of such substances affected his state of mind. He also said he was in debt for drugs. We consider that the prison needs to do more to reduce the availability and the demand for such substances, a matter we have raised with the prison before.

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Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
    - A multidisciplinary approach for all case reviews, with continuity of case management.
    - Healthcare staff attending all first case reviews.
    - That ACCT reviews consider and discuss all risk factors for suicide and self-harm, including the impact of potential bullying or threats and that action is taken.

- The Head of Healthcare should ensure that prisoners receive appropriate mental health support according to their assessed needs, which should be reviewed when they are assessed as at risk of suicide and self-harm.

- The Governor should ensure that allegations of violence, bullying, or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

- The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that prison staff are vigilant for signs of its use and are briefed about how to respond when a prisoner appears to be under the influence of such substances.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. Another investigator visited Ranby on 2 July 2015. He obtained copies of relevant extracts from Mr Levand's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Levand's care at the prison. The investigator and clinical reviewer interviewed nine members of staff at Ranby on 28 and 29 July 2015.

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

16. One of the Ombudsman's family liaison officers contacted Mr Levand's mother to explain the investigation. Mr Levand's mother had no specific issues for the investigation to consider.

Background Information

HM Prison

17. HMP Ranby is a medium security prison, which holds over a thousand sentenced men. Nottinghamshire Healthcare Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

18. The report of the most recent inspection of Ranby in September 2015 has not yet been published. The report of the previous inspection in March 2014 recorded that that there had been increased levels of violence and intimidation with inadequate direct supervision of prisoners. Procedures to tackle bullying and intimidation were poorly understood and not used to good effect. Inspectors noted that incidents of self-harm had risen significantly in the previous year and there had been two recent self-inflicted deaths. The prison's action plan in response to the Prisons and Probation Ombudsman's investigation into one of these deaths was insufficiently detailed.

19. Inspectors were concerned about the easy availability of undetectable new psychoactive substances, other illicit drugs and diverted prescribed medication. The prison had taken some reactive measures in response, but there was no coordinated action plan to reduce drug supply and demand.

20. The prison had a wide range of health services and mental health support was very good. There were effective working relationships between prison and mental health staff but too few officers had received mental health awareness training.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to March 2015, the IMB noted that there was an increasing amount of illicit substances, in particular new psychoactive substances (NPS) in the prison, with an accompanying rise in the level of violence and debt. The IMB was concerned that Ranby did not have 24-hour healthcare cover and noted that increased use of NPS had led to a rise in referrals to the mental health and substance misuse teams.

Previous deaths at HMP Ranby

22. There have been five deaths at Ranby in 2015, including Mr Levand, and one since. The investigations into two of these deaths, identified issues involving new psychoactive substances, bullying and ACCT procedures, which were also issues in this investigation.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process

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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances

24. New psychoactive substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.

25. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence and intimidation.

26. In July 2015, we published a Learning Lessons Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

27. On 13 October 2014, Mr Mark Levand was remanded to HMP Nottingham charged with handling stolen goods and burglary. Mr Levand told reception staff that he had been in prison before, 17 years earlier. He said he had not previously harmed himself and had no thoughts of suicide or self-harm. He had hepatitis C and was referred to a specialist nurse. Mr Levand had symptoms of severe opiate, benzodiazepine and alcohol withdrawal. He was prescribed pabrinex (for alcohol withdrawal), and a methadone maintenance programme (to stabilise the effects of opiate withdrawal). He had been prescribed diazepam for 20 years but began a 21-day benzodiazepine withdrawal programme in line with the prison's established protocol.

28. On 14 October, Mr Levand said he was experiencing withdrawal symptoms and a substance misuse nurse advised him how to manage the symptoms and to seek further help if he did not feel better after three days. Mr Levand said he had suffered from depression in the past and the nurse advised him to let a member of staff know if he started to feel depressed again, so that they could refer him to the mental health team.

29. Mr Levand finished the benzodiazepine (diazepam) withdrawal programme on 2 November. On 5 November, he cut his neck and said it was it because the diazepam had been stopped too quickly. He was treated in hospital and, when he got back to the prison that evening, the duty governor chaired an ACCT case review, attended by a nurse and an officer. He recorded that Mr Levand was in crisis and at high risk of suicide and self-harm. The review decided that he should be constantly supervised, until his medication issues had been resolved. Mr Levand remained on constant supervision for the next five days, after which his observations were reduced. Although Mr Levand's medication had not been altered, he said at the ACCT review that he felt very positive, had no desire to take his life and wanted to return to 'normal'. It was noted that a member of healthcare staff would see Mr Levand for a follow up appointment to discuss his medication.

30. On 6 November, a mental health assessment found no evidence that Mr Levand had an acute mental illness. Mr Levand said he was glad to be alive, but was worried this feeling would not last. A nurse agreed that the primary care mental health team should see Mr Levand again to review his mental health and that he should continue to be supported through ACCT procedures. On 25 November, Mr Levand told a mental heath nurse that he had no thoughts of suicide or self-harm and that he felt able to ask for help if required. The nurse decided that Mr Levand needed a further mental health assessment because of the severity of his recent self-harm.

31. On 26 November, the wing manager and the healthcare manager held an ACCT case review. The wing manager said Mr Levand was in good spirits and said that he did not want to die. They agreed to stop ACCT monitoring. Mr Levand said he understood that he could get support if he needed it.

32. On 8 December, Mr Levand saw a nurse about his hepatitis C. A blood test for hepatitis C on 18 December came back as positive and he was referred for further assessment and management of the condition.

33. On 27 January 2015, Mr Levand was sentenced to two years and six weeks imprisonment. On 4 February 2015, at a high-risk substance misuse review, a GP noted that Mr Levand would usually be expected to begin methadone detoxification because of the length of his sentence, but would continue the maintenance programme for a while, as he was very anxious about his hepatitis C treatment.

HMP Ranby

34. On 6 February 2015, Mr Levand was transferred to HMP Ranby. At an initial health screen, he told a nurse of his history of drug use. He was prescribed 30ml methadone daily, and said he had taken illicitly obtained pregabalin (a drug to treat anxiety) the day before. Mr Levand said he was due to start treatment for hepatitis C, soon. He said he had cut his throat at Nottingham prison in November 2014, because he had been unhappy about his diazepam detoxification. The nurse referred him to the mental health and substance misuse teams.

35. Later that afternoon, a nurse from the substance misuse team reviewed Mr Levand and recorded that he had been prescribed 30ml methadone daily at Nottingham and she continued this dose. She scheduled a substance misuse review for four weeks later.

36. On 10 February, Mr Levand saw a nurse from the mental health team and asked to be prescribed diazepam. He said he had completed a diazepam detoxification but was finding it difficult to cope without it, as he been taking diazepam for 20 years. He said he had felt dreadful during the detoxification and had experienced panic attacks, which had led him to cut his throat. She told Mr Levand that the mental health team would not prescribe him diazepam, which he said he understood. She referred him to the primary care mental health team.

37. A substance misuse nurse reviewed Mr Levand shortly after he saw the nurse from the mental health team, and noted that he was anxious. She said he would not be prescribed diazepam because he could become dependent on it again. Mr Levand spoke about the death of his brother 20 years previously, which had led to his GP prescribing him diazepam. Mr Levand agreed to speak to the chaplaincy about bereavement counselling, because he was still affected by his brother's death. (At an ACCT case review in November 2014, he had told staff that he had supplied drugs to his brother, who had died from an overdose.) Mr Levand agreed to be referred to the hepatitis C clinic to discuss treatment options. He said he had no thoughts of suicide or self-harm.

38. On 16 February, Mr Levand told a GO that some days he felt very low in mood. The GP noted that Mr Levand had an appointment with a mental health nurse on 20 February, when he would be fully assessed. In the meantime, she prescribed him amitriptyline (an antidepressant) to be taken every night.

39. Mr Levand did not go to the hepatitis C clinic on 18 February or a mental health appointment on 20 February. No one followed up the hepatitis C appointment, but a nurse phoned his houseblock to find out why Mr Levand had not attended the mental health appointment. An officer told her that Mr Levand had said he did not need it. She made another appointment.

40. Prison staff monitor a proportion prisoner's mail on a random basis. On 19 February, staff monitoring mail read a letter Mr Levand had written to his mother, in which he asked her to send money to two other prisoners. The staff submitted a security intelligence report and officers were told to monitor Mr Levand. There is no evidence that officers questioned Mr Levand about the letter and asked him whether he was in debt to these prisoners.

41. On 26 February, Mr Levand told officers he was having trouble with certain prisoners in his workshop. Officers asked him to complete a form giving more information the problems he was having, but he did not return it to staff at the time. There is no evidence that officers spoke to the staff who ran Mr Levand's workshop or took any steps to investigate his concerns, such as by questioning or monitoring the prisoners he had asked his mother to send money to.

42. On 4 March, a nurse assessed that Mr Levand was moderately anxious and depressed, but did not have a significant mental health problem. They discussed his previous self-harm and Mr Levand said he had no current suicidal thoughts. He said he was having trouble with prisoners who he had known in the community and who he owed money for drugs. She submitted a security intelligence report about this. (The security department recorded that Mr Levand had already been given a form to complete with more information about his problems with other prisoners. No one followed this up or took any further action.) She noted that Mr Levand had already been referred to the chaplaincy to talk about his brother's death. They agreed that a member of the mental health team would see him every four weeks for support.

43. An addiction psychiatrist reviewed Mr Levand's medication later on 4 March. He noted that Mr Levand should continue the methadone programme and amitriptyline for depression. Mr Levand told him that he was happy with his medication and pleased to be alive.

44. On 18 March, Mr Levand saw the addiction psychiatrist and asked to start his hepatitis C treatment and for sleeping tablets when he began the treatment. The psychiatrist said he would consider prescribing two days of zopiclone to help him sleep, each week when he started his hepatitis treatment. Mr Levand also asked for an increase in his methadone dose when he started treatment, but the psychiatrist told him this would not benefit him.

45. On 25 March, Mr Levand told a nurse that he was doing well and felt settled at Ranby. Mr Levand said that he was still waiting for bereavement counselling. Mr Levand said that he wanted to get on with his hepatitis C treatment. She checked to see when Mr Levand's appointment was. No date had been arranged, so she made a note on the healthcare system to request an appointment.

46. On 26 March, Mr Levand applied for a job as a houseblock cleaner because he said other prisoners at the workshop had threatened him. This was agreed. There is no record that officers submitted a report to the security department or that any other action was taken to support Mr Levand.

47. At 2.00am on 17 April, Mr Levand rang his cell bell and told the night patrol officer that he thought he had had a fit, as he had found himself on the floor. The officer told him to rest on the bed and radioed for staff assistance. Mr Levand pressed his cell bell again and when the officer went back, he was lying on the floor and his head was bleeding. Mr Levand had a plastic knife in his hand and said he had cut his neck and his head. There was also blood on a cupboard in Mr Levand's cell, where he had banged his head. The officer waited by the cell and spoke to Mr Levand until the night manager and response officers arrived at the cell. Mr Levand said that he had taken "Mamba" (a new psychoactive substance) and had then decided to kill himself. Mr Levand was taken to hospital. Officers searched Mr Levand's cell and found three wraps of NPS. They submitted an intelligence report to the security department, but did not charge him with a disciplinary offence for possession of unauthorised articles.

48. Mr Levand got back from hospital at about 11.00am the next morning. His medical records indicate that he was assessed as at high risk of suicide or self-harm and constantly supervised. (The prison has not been able to find Mr Levand's ACCT records for this time.) Mr Levand told a nurse that he had been finding it difficult to cope and had felt unwell, so he had accepted a cigarette, which he believed contained mamba. He said he now felt more stressed because he was being constantly supervised and could not sleep. He said he was under threat in the prison because he owed money for drugs.

49. A mental health nurse attended Mr Levand's first ACCT case review and reviewed his mental health afterwards. Mr Levand said he had thought about ending his life, but had no thoughts of suicide at the time. The nurse concluded that Mr Levand remained at high risk of suicide and self-harm because he was unable to control his anxiety.

50. The next day, 19 April, the mental health nurse reviewed Mr Levand again. Mr Levand was still being constantly supervised. The nurse noted that there was no indication that Mr Levand was at imminent risk of suicide or self-harm, but he still needed mental health support.

51. On 20 April, a GP reviewed Mr Levand and noted that he remained subject to constant supervision. Mr Levand told her he had tried NPS to feel better, but it had made him feel worse. The GP prescribed him mirtazapine (an antidepressant) in addition to the amitriptyline, to see whether it helped his mood.

52. The mental health nurse saw Mr Levand again on 21 and 22 April, who said he had no thoughts of suicide or self-harm and was unhappy that he was still being constantly supervised. At an ACCT case review on 22 April, two nurses, a prison manager and two other officers agreed that Mr Levand's risk had reduced and his level of observations should be reduced to twice an hour. He would still receive mental health support.

53. On 28 April, the mental health nurse recorded that he had seen Mr Levand at an ACCT case review and that Mr Levand's crisis had alleviated. His observations were reduced to three conversations daily and three checks at irregular intervals during the night. The nurse noted that the mental health team would continue to support Mr Levand while he remained at Ranby, and that he had told him to tell staff if he felt his mental health was deteriorating. The same day, 28 April, Mr Levand did not attend an appointment about his hepatitis C. No reason was recorded.

54. On 8 May, a nurse saw Mr Levand for a substance misuse review. The nurse agreed that Mr Levand should remain on 30ml of methadone until he felt more settled. Mr Levand talked about his recent suicide attempt and said that using an NPS had frightened him and that he would not use it again. He said that he was happy with the support he was receiving through the ACCT process. On 11 May, staff ended the ACCT monitoring.

55. On 14 May, the mental health nurse reviewed Mr Levand's mental health. Mr Levand told her that he felt well and had no thoughts of suicide and self-harm. He said he was still under threat from other prisoners so could not go to his job in a prison workshop. He was still assigned to work there, even though staff had agreed he could have a job on the houseblock as a cleaner. (There is no record why he had not started work as a cleaner.) She told Mr Levand that she would no longer be his mental health key worker, but someone else from the mental health team would take over.

56. On 23 May at about 9.20pm, Mr Levand said he had taken 100 paracetamol tablets and was taken to hospital. Tests showed that he had not taken an overdose of paracetamol and he arrived back to the prison at about 2.30am.

57. Soon after Mr Levand left the prison, an officer began ACCT procedures again. He recorded that Mr Levand had said that he had had enough and was worried about a lump on his neck. (When the test results showed that Mr Levand had not taken paracetamol, he had told escorting officers that he had wanted to go to hospital to have his neck checked.)

58. Mr Levand returned to the prison and staff checked him twice an hour. On 24 May, a mental health nurse and an officer tried to assess Mr Levand as part of the ACCT process, but Mr Levand did not want to speak to anyone. Staff continued to check him every half hour and he said he would talk to someone the next day.

59. On 25 May, an officer assessed Mr Levand and recorded that he was concerned about his health, particularly the lump on his neck. Mr Levand said he was worried that his drug use and hepatitis made him at higher risk of cancer. She wrote that Mr Levand was pleased to have the support of ACCT monitoring and that someone from the mental health team was due to see him.

60. After the assessment, a SO and an officer held the first ACCT case review. There were no healthcare staff present. Mr Levand said that he was anxious about his health and also worried that he had no accommodation to go to when he was released. The SO recorded that Mr Levand was at low risk of suicide or self-harm, and staff were asked to check him three times a day and every two

hours at night. The SO completed an immediate action plan, (which should have been completed as soon as ACCT monitoring started). The SO wrote actions on Mr Levand's caremap for him to be referred to the housing service, to the substance misuse team and to have a healthcare appointment to assess the lump on his neck.

61. When Mr Levand was collecting his medication on 25 May, he told a nurse that he had been taking drugs on top of his prescribed medication. She said it was difficult to talk, as she was the only qualified nurse dispensing medication. She arranged to see him later.

62. On 27 May the nurse saw Mr Levand, who said he had been taking pregabalin and physeptone (a synthetic opioid), which he was not prescribed. Mr Levand said he felt he could not manage without these drugs to control his anxiety. He wanted diazepam and a higher dose of methadone, but she explained that this would be too dangerous, as he was using illicit drugs in addition to his prescription. Mr Levand said he was having trouble sleeping and she arranged for him to be prescribed sleeping tablets.

63. On 1 June, Mr Levand completed the form officers had given him in February, when he had reported that other prisoners were threatening him. He wrote that he had problems with drug dealers in the community, who were in the prison and had threatened him when they saw him going to work or to the healthcare centre. He asked for a job on the houseblock instead of the workshop. He said that he could not identify these prisoners and did not know their names. A houseblock officer spoke to Mr Levand about his concerns and Mr Levand said he could not give the names of the prisoners. He said he mixed with other prisoners on the houseblock and collected his meals without any problems. The officer noted that Mr Levand would not be given a different job at that time, although he did not explain why.

64. Later that day, Mr Levand attended a second ACCT case review, with a prison manager and an officer. Mr Levand told them he had no thoughts of harming himself. There is no record that they discussed Mr Levand feeling threatened by other prisoners, his housing issues or his health concerns. The manager assessed Mr Levand's risk of suicide and self-harm as low. He agreed that he should remain on the same level of observations, three conversations a day and checks every two hours at night.

65. On 6 June, Mr Levand's workshop notified houseblock staff that Mr Levand had been absent from work too often and he would no longer be paid. There is no record that anyone spoke to Mr Levand about this, or investigated the connection with his fears about being threatened by other prisoners. No one noted that they had earlier agreed he could have a job as a cleaner.

66. On 8 June, a SO and a nurse held the third ACCT case review. Mr Levand told them that he was waiting to see a substance misuse nurse or a doctor to review his medication and that his housing situation was still being sorted He said that he was still waiting for hepatitis C treatment. The review agreed that he remained at low risk of suicide or self-harm and his level of observations remained the same.

67. On 12 June, Mr Levand told a GP that he was having daily panic attacks and feeling anxious. He asked to be prescribed diazepam, but the GP prescribed him sertraline (an antidepressant) and propranolol (used to treat anxiety), which he considered a more suitable long-term treatment. The GP recorded that Mr Levand had accepted his suggestion well. However, on 13 June, a healthcare assistant recorded that Mr Levand had refused to take the new medication. The prescription for propranolol was stopped on 20 June, but Mr Levand started taking sertraline again on 14 June.

68. On 15 June, a SO and an officer held Mr Levand's fourth ACCT case review with no member of healthcare staff present. Mr Levand said his medication had been reviewed and that he felt much better. He now had a release address and would be able to apply to be released early on home detention curfew. Mr Levand appeared positive throughout the review. As the caremap actions had been completed, the staff decided to end the ACCT monitoring. There was no reference to the threats he said he had received from other prisoners. The SO scheduled a post-closure interview for 22 June.

69. That day an officer from the safer custody team reviewed Mr Levand's form about threats from other prisoners. He recorded that an officer had spoken to Mr Levand, who had no further concerns.

70. On 22 June, a SO saw Mr Levand for the post-closure ACCT review. Mr Levand said he had good support from his family and was happy that his health issues were being addressed. He said that he was not working and would like a job on the houseblock when his medication was stabilised. The SO was satisfied that Mr Levand was not at risk of suicide and no longer needed ACCT support.

71. On 26 June, during a safeguarding meeting, staff discussed Mr Levand, as he had recently been managed under ACCT procedures. A member of chaplaincy said he had spoken to Mr Levand, who had told him that he had no thoughts of harming himself. He had not recorded this conversation. It was agreed that a member of the chaplaincy would check Mr Levand's welfare, although no date was specified. Nothing was recorded about Mr Levand on Saturday 27 June or Sunday 28 June.

Monday 29 June 2015

72. At 7.25am on the morning of 29 June, an officer carried out a roll count to check that prisoners were present in their cells. He said he did not remember checking Mr Levand's cell in particular, but he had not noted any problems at the time.

73. At approximately 9.10am, the officer was unlocking prisoners to collect their medication. He unlocked Mr Levand's cell and thought that he was looking out of the window. He called to him, but Mr Levand did not respond. He moved nearer and saw that Mr Levand was suspended by a belt tied abound his neck and attached to the window bars. He cut the belt and then, at 9.13am, pressed the general alarm bell, just outside the cell. Staff joined him at the cell. He checked Mr Levand for signs of life. His body was warm, but he found no pulse and he was not breathing.

74. The officer should have radioed an emergency code as soon as he found Mr Levand hanged. However, at 9.14am, another officer radioed an emergency code blue, and the control room called an ambulance immediately. There was therefore very little delay. He began chest compressions to try to resuscitate Mr Levand. He said that a number of healthcare staff arrived in the cell, but he carried on with chest compressions.

75. Two nurses responded to the code blue and arrived at the cell two minutes later, at about 9.16am, with emergency equipment. One nurse administered oxygen and the other applied a defibrillator, which found no shockable heart rhythm. A number of other staff arrived at the cell.

76. Paramedics arrived at Mr Levand's cell at approximately 9.33am. The paramedics assessed Mr Levand, and took over emergency treatment. At 10.12am, the paramedics recorded that Mr Levand had died.

Contact with the family

77. The Head of Safer Custody and a chaplain arrived at Mr Levand's mother's home at 12.25pm, and informed her that Mr Levand had died. They offered condolences and support. Mr Levand's funeral was held on 23 July and the chaplain conducted the service. The prison contributed to the cost of the funeral, in line with national instructions.

Support for prisoners and staff

78. A prison manager debriefed the staff involved in the emergency response and offered her support and that of the staff care team.

79. The prison posted notices informing other prisoners of Mr Levand's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by Mr Levand's death.

Post-mortem report

80. The reports of a post-mortem examination indicated that the cause of death was hanging. A toxicology report concluded that, in addition to the medication Mr Levand had been prescribed, he had also taken olanzapine (an antipsychotic drug) and gabapentin (used to treat epilepsy and neuropathic pain), which can produce feelings of relaxation and euphoria.

Findings

Management of risk of suicide or self-harm

81. Mr Levand was assessed as at risk of suicide or self-harm and managed under ACCT procedures for two periods at Ranby, firstly from 17 April until 11 May and then subsequently from 23 May until 15 June, two weeks before his death. We are concerned that the prison cannot find the ACCT documents from the first period. This meant that prison staff might not have had key information about Mr Levand's risk for the second period.

82. Mr Levand initially refused to talk to staff after he said he had taken an overdose of paracetamol tablets on 23 May. Officers and healthcare staff tried to assess him, and checked him twice an hour until he agreed to speak to an ACCT assessor on 25 May, but no one completed a formal immediate action plan until the first case review on 25 May.

83. The ACCT process should be multidisciplinary and include all relevant staff involved in a prisoner's care. Although the ACCT records for the first period of ACCT management at Ranby are missing, there is evidence from Mr Levand's medical records that healthcare staff worked with prison staff to help manage his risk.

84. However, for the second period of ACCT monitoring, a member of healthcare staff attended only one of four ACCT reviews, despite the fact that Mr Levand was receiving support from the mental health team and was anxious about his medication and his physical health. A mental health nurse attended the third case review, but there was no healthcare presence at the first ACCT case review, which is a mandatory requirement of Prison Service Instruction 64/2011. Mr Levand had complex substance misuse needs, but no one from the substance misuse team attended. There was a different case manager for three out of four case reviews.

85. At the same time that Mr Levand was being monitored as at risk of suicide and self-harm, he completed a form with information that he felt unsafe going to his job in a prison workshop or going to the prison healthcare centre, because other prisoners were threatening him. There is no record that this was ever considered as part of the management of Mr Levand's risk of suicide, although this would have increased his risk. Not going to work also meant that Mr Levand spent more time locked in his cell, which is also likely to have increased his risk.

86. We recognise that Mr Levand had not been assessed as at risk of suicide and self-harm for the two weeks before his death. We also recognise that some of the deficiencies we have identified are procedural and there is no evidence that prison staff missed signs that Mr Levand was at increased risk of suicide again immediately before his death. However, we are concerned that not all factors affecting his risk of suicide were considered and there was a lack of consistent case management and multidisciplinary involvement. We make the following recommendation:

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

- **A multidisciplinary approach for all case reviews with continuity of case management.**
- **Healthcare staff attending all first case reviews.**
- **That ACCT reviews consider and discuss all risk factors for suicide and self-harm, including the impact of potential bullying or threats and that action is taken.**

Mr Levand's mental health

87. When Mr Levand arrived at Ranby, he was appropriately referred to, and supported by, the mental health team. The clinical reviewer considered that his mental health care was equivalent to that which he could have expected to receive in the community. His diazepam was reduced at Nottingham in line with the prison's protocol.

88. However, on 14 May, a mental health nurse told Mr Levand that she would no longer be his key worker, but he would be allocated to another member of the team. No other nurse was allocated as Mr Levand's key worker, even after he was assessed as at risk of suicide or self-harm again on 23 May. The nurse attended his ACCT case review on 8 June but there is no record of any ongoing support from a mental health nurse after 14 May until he died.

89. We are concerned that at a time of heightened risk Mr Levand was not allocated a key worker and the mental health team did not review him or contribute effectively and consistently to the management of his risk. We make the following recommendation:

The Head of Healthcare should ensure that prisoners receive appropriate mental health support according to their assessed needs, which should be reviewed when they are assessed as at risk of suicide and self-harm.

Response to allegations of threats

90. In February, Mr Levand told officers that he had problems with prisoners in his workshop. The officers did not investigate Mr Levand's concerns, but asked him to complete a form with more details. No one investigated further when Mr Levand named two prisoners in a letter to his mother which was monitored by staff and which asked her to send money to them. Eventually, he returned the form on 1 June, but staff did not follow this up with him, or take any action despite submitting further intelligence in the meantime.

91. Mr Levand repeatedly said that he did not go to work because he was too scared of other prisoners. He also missed healthcare appointments, apparently because he was wary of leaving the houseblock. He applied for and was approved for a cleaning job on his houseblock, but he never started the job.

92. We are concerned that staff did not investigate Mr Levand's concerns about his safety sufficiently or ensure he was appropriately supported. In the investigation into the death of another prisoner at Ranby in May 2014, who was also afraid to leave his houseblock because of threats from other prisoners, we had similar concerns. In response to our recommendation, the prison said they had implemented procedures to ensure that all allegations of bullying were taken

seriously and investigated and that prisoners in fear of their safety because of debt were offered appropriate support. We saw no evidence of this in response to Mr Levand's concerns. We repeat our previous recommendation:

The Governor should ensure that allegations of violence, bullying, or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

New psychoactive substances

93. In April, Mr Levand admitted that he had taken "Mamba", a new psychoactive substance (NPS). Officers searched his cell and found three wraps of NPS. They told the security department, who took no further action. Although a substance misuse nurse spoke to Mr Levand about the dangers of taking illicit drugs on top of his prescribed medication, there is no evidence that Ranby took any action to determine where, or from whom, Mr Levand had got the drugs.

94. The report of the most recent inspection of Ranby in September 2015 is not yet available, but we note that HM Inspectorate of Prisons was very concerned about the prevalence of NPS at Ranby when they inspected the prison in March 2014. Preliminary feedback from the recent inspection report indicates that this is still a problem. In its most recent report annual report, Ranby's Independent Monitoring Board also identified this as a serious concern.

95. The clinical reviewer considered that Mr Levand received appropriate support for his substance misuse at Ranby. However, we are concerned that the prison did not respond adequately to the security implications of his illicit drug use, including NPS. We repeat a recommendation that we made in the investigation report into the death of another prisoner at Ranby in June 2015:

The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that prison staff are vigilant for signs of its use and are briefed about how to respond when a prisoner appears to be under the influence of such substances.