Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Iverson, a prisoner at HMP Woodhill, on 9 May 2019

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 Kevin Iverson died on 9 May 2019 after he was found hanging in his cell at HMP Woodhill. He was 51 years old. I offer my condolences to Mr Iverson's family and friends.

Mr Iverson had been at Woodhill for six months when he died. For most of that time, he was subject to Prison Service suicide and self-harm procedures (known as ACCT), including two months under constant watch. Staff stopped ACCT monitoring one month before Mr Iverson died.

I am satisfied that there was little indication that Mr Iverson was at imminent risk of suicide when he died and I am not critical of the decision to stop ACCT monitoring on 10 April. However, while there were periods when staff managed the ACCT procedures well, there were periods when there was a lack of input from mental health staff, which was concerning given Mr Iverson's significant mental health issues.

I am concerned at the standard of mental health care Mr Iverson received in the last weeks of his life. I consider that he was discharged from the mental health team prematurely, with little support. Also, several opportunities for the mental health team to re-engage Mr Iverson were missed and concerns passed to the mental health team in the days before he died were not acted upon. I am also concerned that Mr Iverson's non-compliance with his antipsychotic and antidepressant medication was not properly recorded.

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

Sue McAllister CB
Prisons and Probation Ombudsman **January 2020**

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Summary

Events

1. On 13 November 2018, Mr Kevin Iverson was sentenced to six and a half years imprisonment for historic sexual offences against a child. He was taken to HMP Woodhill where staff started suicide and self-harm prevention procedures (known as ACCT). It was his first time in prison.

2. Over the following weeks, Mr Iverson's mental health deteriorated. He told staff he heard voices, felt paranoid and under threat. In December, staff found Mr Iverson with a ligature around his neck. He told them he was innocent and ready to die. Staff put him under constant watch, which continued until February 2019.

3. Staff stopped ACCT monitoring on 8 March, when Mr Iverson's mental health improved. However, staff restarted ACCT monitoring on 17 March, after Mr Iverson told a prison pharmacy technician that he had cut all ties to his family and friends and showed her a letter in which he said he would be "leaving here in a box".

4. On 10 April, the metal health team discharged Mr Iverson from their caseload and staff stopped ACCT monitoring. Towards the end of April, Mr Iverson said that he was having difficulties sleeping and his key worker became concerned about him. Mr Iverson's key worker said he sent several emails to the mental health team (though there is no evidence of these).

5. On 8 and 9 May, a pharmacy technician became concerned about Mr Iverson and told the mental health team. She noted that he was hearing voices again, refusing his medication unless he was prescribed sleeping tablets and was "slipping backwards". The mental health team did not review Mr Iverson.

6. On the afternoon of 9 May, Mr Iverson had a sentence planning meeting with probation staff. He became upset during the meeting and continued to maintain his innocence. Later that afternoon, at 5.35pm, Mr Iverson asked to stay locked in his cell during association. This was not unusual and staff had no concerns about him.

7. At 6.54pm, after all prisoners had been locked back in their cells, an officer carried out a roll check. He was aware that Mr Iverson had been to a meeting with probation staff that afternoon and when he got to Mr Iverson's cell, he said to him that they would speak in the morning. Mr Iverson did not reply so the officer banged on the door and raised his voice, but still got no response. The officer unlocked his cell and found that Mr Iverson had tied a ligature around his neck that was attached to his bed. The officer radioed an emergency code, staff responded, cut him down and tried to resuscitate Mr Iverson. Ambulance paramedics arrived ten minutes later but were unable to resuscitate Mr Iverson and at 7.32pm, pronounced that he had died.

8. Letters Mr Iverson had written to his next of kin were found in his cell after he died. They said he was hearing voices, could not cope with the length of his sentence and did not want to be known for an offence he did not commit.

Findings

Assessment and management of risk

9. We consider that Mr Iverson gave staff little indication that he was at imminent risk of suicide in the weeks before his death and we are not critical of the decision to stop ACCT monitoring on 10 April.

10. We found that the first period of ACCT monitoring was well managed but there was a lack of healthcare involvement in the second period.

Clinical Care

11. The clinical reviewer concluded that Mr Iverson's medical care was of mixed quality and sometimes not equivalent to that he could have expected to receive in the community.

12. The decision to discharge Mr Iverson from the mental health team was made prematurely and without those involved in his care present. After this, there were missed opportunities to re-engage Mr Iverson when prison and healthcare staff voiced their concerns that his mental health was deteriorating. Most notably Mr Iverson should have been urgently assessed when the pharmacy technician informed the mental health team that he was hearing voices again.

13. In addition, we are concerned that Mr Iverson's non-compliance with antipsychotic and antidepressant medication was not adequately recorded.

Allegations against staff

14. We are concerned that there is no evidence that Mr Iverson was assessed by healthcare staff after he was restrained on 13 February.

Support for staff and prisoners

15. Not all staff and prisoners felt adequately supported after Mr Iverson's death.

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 guidelines, in particular that staff hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews.

- The Governor and Head of Healthcare should ensure that:

    - prisoners are appropriately discharged from mental health services;
    - all staff are aware of how to appropriately refer prisoners or pass relevant information to the mental health team;
    - concerns passed onto the mental health team are appropriately managed and all significant information is documented in a prisoner's clinical record, and/or passed onto the relevant medical professional; and

    - mental health staff assess prisoners in line with guidelines and offer follow-up appointments where necessary.

- The Head of Healthcare should ensure that refusal and non-compliance with medication is documented in a prisoner's clinical record, in addition to the medicine administration record. The mental health team should be informed if prisoners refuse antipsychotic medication.
- The Governor and Head of Healthcare should ensure that prisoners are assessed by healthcare staff after being restrained.
- The Governor should ensure that prisoners and staff are offered appropriate support following a death in custody or other traumatic event.

The Investigation Process

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

17. The investigator obtained copies of relevant extracts from Mr Iverson's prison and medical records.

18. The investigator interviewed thirteen members of staff and two prisoners at Woodhill in June. NHS England commissioned an independent clinical reviewer to review Mr Iverson's clinical care at the prison. They jointly interviewed some staff.

19. We informed HM Coroner for Milton Keynes of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Iverson's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Some of these issues have been addressed in separate correspondence. Those below are addressed in the main body of the report. Mr Iverson's mother said that:

    - Other prisoners called Mr Iverson derogatory names and bullied him because of the nature of his offence.
    - Mr Iverson was thrown onto the floor by officers and thought his ribs were broken but he was not assessed by healthcare staff.
    - Mr Iverson's hand was also broken but not treated.
    - Mr Iverson was left alone when he was vulnerable and had attempted suicide previously.

21. Mr Iverson's next of kin received a copy of the initial report. She did not make any comments.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Woodhill

23. HMP Woodhill in Milton Keynes is a complex institution known as a 'core local' prison. As such, it combines a local prison function for just over 600 men with a high security responsibility, holding a small number of category A prisoners, most of whom are going through the court process or have been recently convicted. In addition, the prison operates a close supervision centre (CSC), a specialist facility for some of the country's most disruptive prisoners.

24. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides mental and physical healthcare, including end of life and palliative care.

25. As part of HM Prison and Probation Service's estate transformation, HMP Woodhill was due to become a category B training prison in 2018. At the time of writing this has not yet happened.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Woodhill was in February 2018. Inspectors reported that the number of recorded self-harm incidents had increased and was much higher than at similar prisons. The number of prisoners being managed under ACCT procedures was very high, so staff struggled to give them the attention they needed.

27. There had been some good actions to improve suicide and self-harm prevention systems but, overall, the prison had failed to sustain this work. Some aspects of the ACCT process had improved and were generally better than seen elsewhere. There was better multidisciplinary attendance at review meetings and assessments were now completed by the dedicated safer custody group. Caremaps, overall, had sensible, achievable actions. However, there were still some weaknesses, especially around understanding triggers. Documents were often chaotic, which meant that risk information was not readily available.

28. Inspectors found that the mental health team was well-integrated with the rest of the prison and regularly involved in ACCT reviews and prison-wide meetings to support prisoners with complex needs. They found that referrals were received to a dedicated email box, reviewed and actioned appropriately.

29. Inspectors reported that the response to violence required improvement: while most incidents were investigated, the challenge and monitoring of perpetrators on residential units was poor. Support for victims of bullying and violence was also underdeveloped.

Independent Monitoring Board

30. 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 31 May 2018, the IMB reported that the proportion of prisoners being managed under ACCT remained high. While some innovative work had been done in developing safer custody

strategies, the management of ACCTs was inconsistent. Levels of violence were high. Healthcare services had performed well against challenging staffing problems.

Previous deaths at HMP Woodhill

31. In 2015 and 2016, a total of 12 prisoners took their lives at Woodhill, a much higher figure than at comparable prisons. There were no self-inflicted deaths at all in 2017 and one in 2018. In 2019, there have been four self-inflicted deaths, including Mr Iverson's.

32. Previous PPO investigations identified deficiencies in ACCT management, notably the absence of healthcare staff from case reviews. We also found that victims of bullying were not being properly supported in line with Woodhill's Violence Reduction Strategy.

Assessment, Care in Custody and Teamwork (ACCT)

33. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

34. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

35. On 13 November 2018, Mr Kevin Iverson was sentenced to six and a half years imprisonment for historic sexual offences against a child. He told court staff that he was on hunger strike due to being convicted of an offence he did not commit. Mr Iverson was taken to HMP Woodhill. It was his first time in prison. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT) due to the statement he had made in court. Mr Iverson was classed as a vulnerable prisoner due to the nature of his offence and staff planned to move him to a vulnerable prisoner house unit once a space became available.

36. During his reception health screen, Mr Iverson told a nurse that he had taken an overdose around 20 years ago and had received treatment intermittently for depression and anxiety since 2010. He had irritable bowel syndrome (IBS) which resulted in him sometimes being incontinent, type 2 diabetes and lower back pain. He requested a single cell due to his medical conditions. The nurse referred Mr Iverson to a GP due to his health conditions, alcohol use and prescribed medication. The nurse also referred him to mental health and substance misuse services. A GP prescribed medication to manage Mr Iverson's withdrawal symptoms from alcohol, painkillers for his back and sertraline (antidepressant) along with other medication.

37. On 14 November, Mr Iverson told an officer that he was not on hunger strike and had only said this due to being angry and upset. During his ACCT assessment that morning, he said he felt more relaxed and had no thoughts of self-harm or suicide. He asked to see a nurse. The nurse assessed him as suitable for a single cell due to his medical issues.

38. On 15 November, a mental health nurse met Mr Iverson. She noted that he suffered from depression and anxiety and referred Mr Iverson for a full mental health assessment. He told the nurse that he had no thoughts of suicide or self-harm.

39. On 17 November, Mr Iverson's stepfather rang the prison and told staff that he was concerned about Mr Iverson's welfare. Staff spoke to Mr Iverson and he said he could not cope with being in prison for an offence he did not commit. He said that he had considered overdosing on the medication he had in his possession. The officer took this medication (26 mirtazapine tablets – used to treat anxiety and depression) which Mr Iverson said he had brought into prison with him. It is not clear how Mr Iverson managed to have these tablets in his possession.

40. On 18 November, Mr Iverson told staff that he had planned to take his own life the night before.

41. On 19 November, a mental health nurse assessed Mr Iverson. Mr Iverson was tearful but said he had no thoughts of suicide or self-harm. The nurse referred him to the GP for a review of his antidepressant medication. On 21 November, a GP reviewed Mr Iverson who told him that he was being bullied on the induction unit and wanted to move to the vulnerable prisoner house unit as soon as possible. The GP increased Mr Iverson's prescription of antidepressants.

42. On 22 November, Mr Iverson said that he was having thoughts of self-harm. Staff immediately held an ACCT review. The next day, staff moved him to house unit 4B, for vulnerable prisoners. Staff held regular ACCT reviews with prison and healthcare staff present.

43. On 27 November, Mr Iverson told staff that he had heard three prisoners outside his cell door threatening to stab him. He could not name them. On 2 December, during ACCT checks, overnight staff became concerned about Mr Iverson as he was sitting in the dark with a letter in his hand. When asked, he gave staff the letter which did not indicate any intention to take his life. It said that he heard voices and wanted to be assessed by mental health staff. The officer emailed the mental health team.

44. On 5 December, a GP increased Mr Iverson's prescription of antidepressants.

45. On 6 December, an offender supervisor met with Mr Iverson. He asked her which prison he would be moving on to. She said he would most likely go to HMP Littlehey. Mr Iverson said that he would like to be in the Northampton area near his family.

46. On 7 December, staff submitted an intelligence report after Mr Iverson said he felt threatened on the wing. He said he had told a Listener (a prisoner trained by the Samaritans to provide support to other prisoners) what offence he had been convicted of, they had told others, prisoners were now ignoring him and had threatened to assault him.

47. On 8 December, during an ACCT check, an officer found Mr Iverson with a ligature around his neck attached to his window bars. He removed it when asked and told staff that he had tied it due to the length of his sentence and being innocent. He said that other prisoners on the wing had found out the nature of his offence and had been shouting it out the window. He said he was ready to die and had written several suicide notes. The Head of Operations authorised Mr Iverson to be put under constant watch. He managed Mr Iverson's ACCT while he was subject to constant watch.

48. The offender supervisor spoke to Mr Iverson. He said he could hear voices and had no idea why he was in prison. He said he "would not return to Woodhill", and if he did, he would "do something". She recorded that this represented a significant change in Mr Iverson's presentation. Over the following days, staff conducted constant watch reviews, with nurse's present. Mr Iverson displayed paranoid thoughts and behaviour and said he could hear voices.

49. On 13 December, Mr Iverson's next of kin telephoned the prison and told safer custody staff that she was concerned as she had not heard from Mr Iverson since he had attempted to take his own life. Staff passed her concerns to the head of operations, who was chairing an ACCT review later that day. They also asked Mr Iverson to telephone his next of kin as soon as possible. He rang her shortly afterwards. Mr Iverson displayed unusual behaviour, hallucinating, hearing voices and talking to people who were not in his cell. Mr Iverson tied a ligature to his window bars on 15 December and demanded that staff let a police officer into his cell. Staff noted his behaviour was bizarre and that it was very difficult to engage him in any meaningful conversation.

50. On 18 December, a nurse discussed Mr Iverson with a psychiatrist. She was concerned about his deteriorating mental state. The psychiatrist discussed Mr Iverson with a GP. They agreed a plan to eliminate any physical cause for his mental state, including blood and urine tests. The psychiatrist planned to review Mr Iverson after the results of these tests were known.

51. On 20 December, the psychiatrist assessed Mr Iverson. He concluded that Mr Iverson's current presentation was most likely an "acute stress reaction to his current circumstances". Mr Iverson had declined blood tests. The psychiatrist prescribed Mr Iverson quetiapine (antipsychotic medication).

52. The head of operations continued to chair regular ACCT reviews with mental health staff present. On 3 January 2019, the psychiatrist assessed Mr Iverson. Mr Iverson had not taken most of his antipsychotic medication. He said he did not like the side effects and felt it was unnecessary. Mr Iverson said that he felt stressed and was struggling to adapt to being in prison but said he had no thoughts of suicide.

53. During an ACCT review later that day, the head of operations noted that Mr Iverson was much more coherent and they could have a normal conversation. Mr Iverson said that he had no thoughts of suicide or self-harm and was desperate to stop being under constant watch. The head of operations noted that he, the Deputy Head of Healthcare, and the psychiatrist were concerned that Mr Iverson was trying to stop the constant watch so that he could harm himself. Staff told him his behaviour would be reviewed over the next few days.

54. On 12 January, a nurse assessed Mr Iverson as he had been making ligatures in his cell. On 14 January, Mr Iverson was allocated to a mental health nurses caseload. Another nurse was also the Mental Health Team Manager. During an ACCT review on 15 January, staff recommended that Mr Iverson be moved to the Clinical Assessment Unit (CAU) for further assessment. This is a much smaller inpatient unit with 12 beds and nurses present 24 hours a day. Mr Iverson continued to refuse to take his antidepressant and antipsychotic medication.

55. The psychiatrist reviewed Mr Iverson. He indicated that he continued to have psychotic symptoms, paranoia and symptoms of thought disorder. They discussed Mr Iverson's continued non-compliance with medication and the psychiatrist encouraged Mr Iverson to take it.

56. On 4 February, staff moved Mr Iverson to the CAU. On 7 February, the psychiatrist assessed Mr Iverson and noted that his mental state had significantly improved. He noted that there was no longer any evidence of formal thought disorder and he was not distracted by hallucinations during their meeting. Mr Iverson's thoughts had become more logical, but he remained impulsive and there was evidence of his ongoing difficulty managing frustration. The mental health team manager also attended the review. This was the first time she had met Mr Iverson since he had been allocated to her caseload since she had just returned from annual leave.

57. On 12 February, an officer introduced himself as Mr Iverson's keyworker. (Key workers have replaced personal officers as a prisoner's first point of contact.

Each key worker is responsible for five or six prisoners and is expected to have a meaningful conversation with each of them at least once every two weeks.) The head of operations chaired an ACCT review later that day. During the review, Mr Iverson engaged well, had good eye contact and was relaxed. He said he preferred the smaller, quieter environment of the CAU and had no thoughts of suicide or self-harm. Staff reduced his observations to five an hour. Mr Iverson was pleased about this.

58. On 13 February, Mr Iverson was threatening towards officers, was restrained and taken back to his cell. He was more settled the next day and said he had been hearing voices. During a review of his behaviour, healthcare staff noted that it had been variable over the last week. He was associating more with prisoners, attending groups on the unit and exercising.

59. During an ACCT review on 15 February, staff reduced Mr Iverson's observations to two an hour. On 19 February, his keyworker tried to speak to Mr Iverson but he was asleep and did not want to engage. Wing staff told him that Mr Iverson was much more stable, coping well and was having regular telephone calls with his family. Mr Iverson's behaviour was variable over the next few days, sometimes settled, but at other times threatening and rude towards staff.

60. On 21 February, CAU staff, including the psychiatrist, reviewed Mr Iverson. They discussed that he appeared to have had a severe adjustment reaction to prison which was now stabilising. Mr Iverson said he did not think that being prescribed quetiapine was helping him and the psychiatrist agreed to stop this medication, since he had not been compliant with it and appeared to be improving. They agreed that Mr Iverson would move back to House Unit 4B if he was stable for the next week. Staff agreed to reduce Mr Iverson's ACCT observations to one an hour.

61. On 4 March, staff reduced Mr Iverson's observations to two conversations during the day and hourly observations at night. Mr Iverson moved to House Unit 4B later that day. A prisoner had been on the house unit since Mr Iverson had first arrived at Woodhill. He told the investigator that Mr Iverson was a lot quieter when he returned to the house unit.

62. On 7 March, Mr Iverson made a request to remove all telephone numbers from his prison telephone account. Staff were concerned about this and spoke to Mr Iverson who said he had changed his mind. He had been angry at his family who were not visiting him. He said he had no thoughts of suicide or self-harm.

63. On 8 March, staff held an ACCT review. Mr Iverson remained upset about his conviction but said he was now keen to move to another prison and appeal his conviction. Mr Iverson had settled well since moving back to a standard wing. Staff stopped ACCT monitoring.

64. On 16 March, his keyworker had a key worker session with Mr Iverson. They discussed a potential transfer the following week and Mr Iverson said he would like to become more settled and seek employment in prison. He said his next of kin, who he had not seen for 14 years, had been in contact with him and this had given him a purpose.

65. On 17 March, Mr Iverson told a pharmacy technician during his secondary health screen, that he had asked his next of kin to sell his belongings and rehome his dog. He appeared low in mood and said he was angry at his current situation. Mr Iverson also said he had written to his friends and family to cut his ties. He showed her one letter which said, "*I will be leaving here in a box.*" She asked him whether he had any thoughts of suicide or self-harm but Mr Iverson would not answer her question. She spoke to a wing officer and started ACCT procedures.

66. On 18 March, the mental health team manager met Mr Iverson. She told the investigator that he seemed more relaxed and engaged well with her. She had no concerns that he was a risk to himself. Mr Iverson said that he thought his mental health had deteriorated when he arrived in prison due to stress and the length of sentence he had received. He said that when he attempted suicide, he was not thinking straight but now had evidence to prove his innocence. He said his next of kin had recently contacted him. The nurse noted that she would review Mr Iverson in the wing clinic and planned to discuss him at the multidisciplinary team meeting for discharge from the mental health team.

67. During the ACCT assessment, Mr Iverson told staff that he had no intention of killing himself. He claimed that his letters had been misinterpreted and his comment about leaving prison in a box was a "stupid one to make" but that was how he sometimes felt due to the length of his sentence. He said he was going to appeal his sentence and wanted to contact his next of kin. He said he had regular contact with his next of kin.

68. The offender supervisor saw Mr Iverson and they discussed scheduling his sentence planning meeting. She old the investigator that Mr Iverson had started to sound more positive and was keen to transfer to HMP Littlehey. She said that they needed to complete his sentence plan before a prison would consider him for transfer. On 26 March, Mr Iverson told his keyworker that he was getting on well with his cellmate and felt settled. The officer noted that he was "much more positive" than previously.

69. On 31 March, Mr Iverson submitted a complaint to the Governor. He alleged that he had been assaulted by staff resulting in broken ribs, bruising and concussion. Mr Iverson indicated that he had reported the attack to prison and healthcare staff but no action was taken. He also alleged that he had been mentally tormented when on constant watch.

70. On 1 April, Mr Iverson told his keyworker that he would like a different cellmate. The officer noted that he appeared distant and did not want to engage with them. The keyworker recorded that he emailed the mental health team requesting that they assess him. On 2 April, the offender supervisor sent Mr Iverson a memo informing him of his sentence planning meeting on 9 May. Staff held regular ACCT reviews and gradually decreased his level of observations.

71. The pharmacy technician told the investigator that Mr Iverson's mood and demeanour fluctuated daily. Sometimes he would be talkative but at other times he did not want to engage at all. On 8 April, the prison police intelligence officer responded to Mr Iverson's complaint that he had been assaulted by staff. The officer wrote that if Mr Iverson wanted to pursue the allegations, he needed to

report the incidents to the police along with details of when they took place and who was involved.

72. On 9 April, the team manager saw Mr Iverson in the wing clinic. Mr Iverson discussed his bladder issues which woke him up at night. The nurse advised him to speak to the GP. He said that he felt "alright" and he appeared stable. He said he had no thoughts of suicide or self-harm. The nurse noted that she would discuss Mr Iverson in the multidisciplinary meeting with the view to discharging him from mental health services. She told the investigator that she thought Mr Iverson was no longer in crisis and could re-engage with the team at any point. She had no concerns he was a risk to himself.

73. On 10 April, around midday, healthcare staff discussed Mr Iverson at the multidisciplinary meeting and agreed to discharge him from mental health services. They noted that Mr Iverson was aware of how to self-refer or attend a wing clinic. The mental health team manager, a nurse and the psychiatrist were not present at the meeting. The notes of the meeting indicated that Mr Iverson was not currently on an ACCT (which was incorrect).

74. Staff decided to stop ACCT monitoring at a review that afternoon at 2.30pm. They noted that Mr Iverson was no longer in crisis. A Supervising Officer (SO), who chaired the review, told the investigator that Mr Iverson had become more hopeful about the future and was associating with other prisoners more. Mr Iverson showed staff a letter he was writing to his solicitor to appeal his sentence. Mr Iverson said he had no thoughts of suicide or self-harm. A nurse had given oral information to the review, although he had not attended himself. It is not clear whether staff were aware that Mr Iverson had been discharged from the mental health team that morning.

75. The SO saw Mr Iverson on 13 April, he said he had met with his solicitor and was hopeful about his appeal.

76. A prisoner said that sometimes Mr Iverson did not collect his lunch and gave his breakfast pack to other prisoners. He said that Mr Iverson visibly lost weight over the following weeks. Mr Thomas said that Mr Iverson used his cell bell more, asking staff to lock him in his cell during association but then changing his mind a short time later and calling them back to unlock him. He thought this was a "cry for help". The prisoner said Mr Iverson started isolating himself more and he was concerned that Mr Iverson was a risk to himself.

77. Another prisoner said that he got to know Mr Iverson after he moved into a cell next door to him on 13 April. He said that Mr Iverson's demeanour changed daily, some days he would be very talkative and others very quiet. Mr Iverson often gave him his breakfast cereal in return for tea or coffee.

78. On 17 April, staff spoke to Mr Iverson to conduct his ACCT post-closure review. Mr Iverson said that he was in a "much better place now". On 22 April, his keyworker met Mr Iverson. He noted that Mr Iverson seemed distant, paranoid, his replies were "short" and "blunt" and he seemed "on edge". The keyworker spoke to wing staff who said that this was typical behaviour for Mr Iverson. He emailed the mental health team.

79. On 29 April, Mr Iverson told an officer that he had not slept for five days and was starting to hear voices. The officer spoke to a member of healthcare staff about the possibility of medication to help Mr Iverson sleep and that he needed a mental health assessment. The officer told the investigator that he could not recall who he spoke to. He said he had no concerns that Mr Iverson was a risk to himself.

80. The pharmacy technician collected the applications from the house unit that day. Mr Iverson had requested sleeping tablets and she forwarded this request to a GP. The GP, prescribed Mr Iverson six days' worth of promethazine hydrochloride (sleeping tablet).

81. An officer knew Mr Iverson throughout his time at Woodhill and told the investigator that he thought he was slowly making progress. He said that sometimes Mr Iverson liked his own space and would stay in his cell during the association periods. However, he said that towards the end of April, Mr Iverson had started playing pool with other prisoners and was socialising more. The officer said that Mr Iverson did not like being in large groups or noisy environments. He tended to socialise with the quieter prisoners.

82. On 2 May, Mr Iverson told his keyworker that he was still waking at night despite taking sleeping tablets. He asked to see a GP and keyworker recorded that he sent an email to healthcare staff requesting this. Mr Iverson said that having contact with his next of kin was not possible at the moment and he had been in touch with a private investigator about his appeal. The keyworker recorded that Mr Iverson was in "good spirits", still "slightly on edge" but more settled than previous weeks. He sent an email to the mental health team with his observations.

83. On 5 May, Mr Iverson refused his lunch and dinner and said he did not want his medication. On 7 May, the offender supervisor told Mr Iverson that his sentence planning meeting would take place on 9 May. A nurse collected the applications from the unit that morning. Mr Iverson had requested a repeat prescription of sleeping tablets. His last course had finished two days previously. The nurse went to see Mr Iverson and explained that GPs preferred there to be seven days between prescriptions of sleeping tablets to avoid prisoners becoming dependent on them. She told the investigator that Mr Iverson seemed "happy" and said he would reapply for the medication the following week. The nurse said that if Mr Iverson had not been satisfied with her response, she would have forwarded the application to the GP. She had no concerns about him. She did not notice whether Mr Iverson had lost weight.

84. An officer told the investigator that he spoke to Mr Iverson around this time. He did not have any concerns and thought that he was in a "reasonable place considering his recent past, and felt that he was interacting more with staff and prisoners". On 8 May, Mr Iverson told his keyworker that he was "fine" but the officer noted that he appeared distant, did not make eye contact or fully engage in their conversation. Mr Iverson said that he had no issues on the wing, and he had not heard from the private investigator but was positive about it. The keyworker noted that he sent an email to healthcare staff.

85. The keyworker told the investigator that Mr Iverson had settled well on the houseblock once he returned from the CAU and his behaviour improved. He said that Mr Iverson opened up to him about his family and his distant relationship with his next of kin. Although Mr Iverson found this distressing, his keyworker said that he thought that Mr Iverson was relieved to talk about it and would thank him for their sessions. He said that Mr Iverson seemed more positive, and appeared to be coming to terms with his sentence and the shock of being at Woodhill. He did not have any concerns that Mr Iverson was at risk of suicide or self-harm.

86. A pharmacy technician emptied the wing application box that morning. Mr Iverson had requested to see a nurse about a rash on his skin so she added him to the nurse's waiting list. At 3.15pm that afternoon, staff noted that Mr Iverson was going to be kept in his cell for the rest of the day as he had threatened staff. An officer spoke to him after this and understood that he had been upset about a small issue which had escalated. Mr Iverson calmed down and spoke to the officer for about 30 minutes. The officer told the investigator that Mr Iverson was let out of his cell that evening and told the officer that he was worried about his meeting with probation staff the next day and said that he was not going to go. The officer encouraged him to attend the meeting to find out what it was about.

87. At 4.45pm, Mr Iverson went to the medication hatch and told the pharmacy technician, that unless he was prescribed sleeping tablets he was going to refuse his medication. She sent an electronic task (a request for action) to the mental health team to inform them. This said, "Mr Iverson seems to be slipping backwards. He has admitted that he is hearing voices again and is now refusing his medication unless he is put back on sleepers. Just sending this task to keep you updated." This task was never actioned. She had dispensed Mr Iverson's medication throughout the time he had been at Woodhill and told the investigator that his behaviour that day was markedly different to recent weeks.

Events of 9 May 2019

88. On 9 May, at 9.15am, Mr Iverson went to the medication hatch and again refused his medication until he received sleeping tablets. He returned to the hatch a few times asking for sleeping tablets. He then changed his mind and took his medication that morning. Mr Iverson also said that he was hearing voices but that they were under control. The pharmacy technician informed a nurse at the daily multidisciplinary lunchtime handover that she was concerned about Mr Iverson.

89. An officer spoke to Mr Iverson about his meeting later that afternoon with his offender manager. Mr Iverson was nervous about what would be discussed. Around 2.00pm, Mr Iverson went to the legal visits department for the meeting with the offender supervisor, his offender manager and a trainee probation officer. This was to complete Mr Iverson's offender assessment and sentence plan. The professionals present had agreed that, due to the issues Mr Iverson had faced earlier in his sentence, they would predominantly focus on his well-being rather than challenging his behaviour.

90. Both the offender manager and the offender supervisor told the investigator that Mr Iverson was very distracted during the meeting by his legal team being in the

room next door by coincidence. The rooms were soundproofed but separated by glass. Mr Iverson blamed his legal team for his conviction as he felt they had not adequately represented him and had ignored evidence which proved his innocence.

91. The offender manager told the investigator that Mr Iverson seemed quite confused and erratic but she did not see any evidence that he was hearing voices. She did not have any concerns that Mr Iverson was a risk to himself. She said it was the first time he had spoken about a lot of the things they discussed and he seemed overwhelmed and was tearful at times. During the meeting, they discussed Mr Iverson's upbringing, employment and relationships. She told the investigator that she thought he found it difficult to hear about his potential release date. Mr Iverson also said that he had lost a lot of weight. She said this was noticeable from the photo she had received and his clothes were too big for him. They tried to discuss it further but Mr Iverson kept changing topics and got distracted. He also said he was having difficulties sleeping.

92. The offender supervisor had to leave before the end of the meeting. Mr Iverson asked her to come and see him in a few days, which she agreed to do. The offender supervisor told the investigator that she had no concerns that Mr Iverson was a risk to himself. The offender manager finished the meeting by giving Mr Iverson her office address for him to write to if he wanted and said she would be in contact in the future.

93. Mr Iverson returned to the wing after his meeting. A prisoner asked him how the meeting had gone, to which Mr Iverson replied, "You don't want to know." He thought that Mr Iverson did not want to speak further about it. A little later, Mr Iverson went into his cell and gave him his cereal and snacks. Mr Iverson had never given him his snacks before so he checked he did not want them. Mr Iverson shrugged his shoulders and returned to his cell. He did not notice that Mr Iverson had noticeably lost weight. He thought that Mr Iverson was struggling generally in prison but that this was not specifically connected to Woodhill. He did not have any concerns that Mr Iverson was a risk to himself.

94. At 4.45pm, the pharmacy technician, gave Mr Iverson his medication. She told the investigator that he was calm and chattier than usual. He said, "I'll see you tomorrow Miss" which he had never said to her before.

95. An officer did not have the opportunity to speak to Mr Iverson about how the meeting had gone but saw him briefly and said he would speak to him later. Staff locked prisoners in their cells and completed the roll check. At 5.35pm, the officer unlocked prisoners for their evening association. Mr Iverson was sitting on the raised section at the back of his cell by the window. Mr Iverson said that he wanted to stay in his cell and asked the officer to lock his door so he could have some privacy. The officer told the investigator that this was not unusual for Mr Iverson, who often did not come out of his cell for evening association. Mr Iverson did not want to talk further so the officer told him to press his cell bell if he changed his mind and wanted to be unlocked. The officer had no concerns about Mr Iverson.

96. Later, all prisoners had been locked back in their cells and the officer was doing his roll check. When he looked through Mr Iverson's observation panel he saw

that he appeared to be sitting in the same place at the back of the cell, leaning on the bed. The officer told Mr Iverson that they could talk in the morning. Mr Iverson did not reply and the officer banged on his cell door and raised his voice but Mr Iverson still did not respond.

97. The officer unlocked Mr Iverson's cell, since it was unusual for him to ignore staff. At that point, he saw that Mr Iverson was suspended from the bed frame by a ligature he had tied using a short piece of sheet. The officer radioed a code blue. (This is an emergency code used to indicate a prisoner is either unconscious or having difficulty breathing.) The control room log recorded it was 6.54pm. Staff in the control room called an ambulance immediately.

98. A second officer was on the same landing and got to the cell within seconds. He noted that Mr Iverson was grey, unconscious and not breathing. The officer cut Mr Iverson down with his anti-ligature knife while the second officer supported his weight. They laid Mr Iverson on the floor outside his cell where the officer started cardiopulmonary resuscitation (CPR). The second officer radioed to confirm that they needed healthcare staff and an ambulance. The pharmacy technician got to the cell a minute later and began administering breaths while an officer collected the medical equipment required. Staff attached a defibrillator and administered oxygen. A GP also attended and inserted an airway.

99. Paramedics arrived at the main gate at 6.59pm and got to Mr Iverson at 7.04pm. They took over his care but were unable to resuscitate him and at 7.32pm, declared that Mr Iverson had died. Staff moved Mr Iverson back into his cell.

100. Staff found notes addressed to Mr Iverson's next of kin in his cell. In one, he indicated that Woodhill had nothing to do with his decision to take his own life. He wrote that he did not want to be known for an offence he did not commit. Mr Iverson also wrote, "It's the non-stop voices in here that won't stop." He noted several staff epaulette numbers but it was not clear why. Mr Iverson also alleged that some officers had mentally tormented him. In another note, he stated that he could not cope with the length of his sentence and being on the sex offenders' register for life. He wrote that if he did not take his own life in prison he would do so when he was released. Mr Iverson wrote that the pain and anguish in prison got worse every day.

101. Documentation showed that Mr Iverson was due to transfer to HMP Bure the day after he died. The offender supervisor told the investigator that she had not told Mr Iverson about this transfer and did not think that he was aware of this. She thought that Mr Iverson had been identified to transfer that day as the prison needed to transfer someone specifically to Bure. She said that staff would normally tell prisoners the day they are transferring when they are unlocked. She did not think that wing staff would have known about the transfer at that point.

Contact with Mr Iverson's family

102. A Custodial Manager (CM) and an operational support grade (OSG), were appointed as family liaison officers (FLO). They went to Mr Iverson's next of kin's address, arriving at 10.00pm. Mr Iverson's next of kin were not home but a neighbour said that they would be home soon so staff waited in the car outside the address. When they returned at 11.30pm, the FLO broke the news of Mr

Iverson's death to them and offered his condolences. Mr Iverson's next of kin said that she had spoken to Mr Iverson on the telephone that morning, and that he had given no indication of being in crisis or that he was going to kill himself.

103. It was not possible for the investigator to listen to the telephone calls Mr Iverson made during the last nine days of his life. The investigator asked for the call recordings at the start of the investigation, but the prison delayed sending them. By the time the investigator received them and realised that the last nine days of calls were missing, they had been automatically deleted (90 days after the calls were made).

104. A FLO stayed in contact with Mr Iverson's next of kin over the following days and, in line with Prison Service policy, offered a financial contribution to Mr Iverson's funeral.

Support for prisoners and staff

105. After Mr Iverson's death, the Head of Special Units debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. All staff involved in the emergency response felt well supported. However, some of those who had been involved in Mr Iverson's care over a prolonged period, such as a SO and the offender supervisor, said that no one had initially checked on their welfare.

106. The prison posted notices informing other prisoners of Mr Iverson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Iverson's death. Of the two prisoners we spoke to, one said that he would have liked more support and was still waiting for mental health staff to assess him at the time of interview.

Post-mortem report

107. The post-mortem report said that Mr Iverson's cause of death was asphyxia caused by hanging.

Findings

Assessment and management of risk

108. Mr Iverson was subject to ACCT procedures from his arrival at Woodhill in November until 8 March and from 17 March to 10 April.

109. During the first ACCT, Mr Iverson was subject to constant supervision for two months between December and February, after which time his observations were gradually reduced until the ACCT was closed. During this first period we are satisfied that Mr Iverson's ACCT was well managed, reviews were appropriately multidisciplinary and prison and healthcare staff made concerted efforts to reduce Mr Iverson's risk to himself.

110. However, we have some concerns about the management of the second ACCT. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, says that ACCT case reviews should be multidisciplinary where possible, and that healthcare staff should always attend the first case review. Healthcare staff did not attend any of the eight reviews held. This was inappropriate, particularly given Mr Iverson's recent psychotic history, its link to his risk to himself and that he was allocated to a mental health team manager caseload at the time. The Deputy Head of Healthcare said that mental health staff are now expected to attend all ACCT reviews. She said that this has reduced the number of open ACCTs and has helped the mental health team to achieve greater consistency of care.

111. Mr Iverson was discharged from the mental health team the morning of 10 April. The notes from the meeting indicate that he was not on an ACCT at that time. This was incorrect as the ACCT was not closed until that afternoon. It is not clear whether staff at the ACCT review were aware Mr Iverson had been discharged from the mental health team that morning. What is clear is that on 10 April, two sources of ongoing support were withdrawn from Mr Iverson within hours of each other. If ACCT reviews had been multidisciplinary this would have allowed for more defensible and informed decisions to have been made.

112. 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 guidelines, in particular that staff hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews.

113. Aside from this, we are not critical of the decision to close Mr Iverson's ACCT on 10 April. Mr Iverson had returned to the house unit from the CAU, settled well and appeared to be more positive about his future. Mr Iverson took his own life a month after the ACCT was closed. During that month, Mr Iverson's mood and mental health appeared to fluctuate. He told some staff that he was hearing voices again and they documented that they passed these concerns to the mental health team. Unfortunately, the mental health team never reassessed Mr Iverson (this is discussed in more detail below). None of the prison staff we spoke to thought that Mr Iverson was a risk to himself.

114. Mr Iverson had clearly been concerned about his sentence planning meeting which occurred the afternoon that he died. Those present acknowledged that he was upset during the meeting, but they had no concerns that he was a risk to himself. One of those present, the offender supervisor, had been Mr Iverson's offender supervisor since he arrived at Woodhill.

115. The notes that Mr Iverson left indicated that he had not shared the depths of his distress with staff and had concealed his true intentions from those around him. In these circumstances, we do not consider that staff could have been expected to predict or prevent Mr Iverson's actions that afternoon.

Clinical Care

116. The clinical reviewer concluded that Mr Iverson's clinical care was of mixed quality and sometimes was not equivalent to the care he could have expected to receive in the community.

Mental Health Care

117. On 10 April, Mr Iverson was discharged from mental health services, the same day his ACCT was closed. His care coordinator, the mental health team manager, had limited contact with Mr Iverson and the decision to discharge him was made at a multidisciplinary meeting at which neither she, the psychiatrist nor a nurse were present. The clinical reviewer concluded that from this point onwards, Mr Iverson's mental health care was inadequate. The clinical reviewer concluded that given Mr Iverson's previous presentation it would have been prudent to offer a longer period of follow-up.

118. The Deputy Head of Healthcare agreed that perhaps Mr Iverson was discharged from the mental health team prematurely. She said that changes have now been implemented requiring care coordinators to be present at meetings when a prisoner is discharged from mental health services.

119. We are concerned that after Mr Iverson was discharged from the mental health team, they missed opportunities to re-engage with him. The keyworker said that after Mr Iverson was discharged from the mental health team, he had concerns that Mr Iverson's mental health could decline again. He said that he spoke to wing nurses about this. He recorded that he emailed his concerns about Mr Iverson to healthcare staff or the mental health team on 1 April, 22 April, 2 May and 8 May. He could not provide evidence of these emails as he told the investigator that his computer account had been reset since that time. The mental health team manager checked the mental health team's inbox and could not find any evidence of these emails. The Deputy Head of Healthcare was certain that all staff knew how to email referrals to the mental health team. There is no evidence of these emails in Mr Iverson's medical record.

120. In addition, an officer recorded that he spoke to healthcare staff on 29 April about his concerns regarding Mr Iverson, that he was hearing voices, was requesting sleeping tablets and needed a mental health assessment. There is no evidence of this conversation in Mr Iverson's clinical record or that any action was taken.

121. On 8 May, the pharmacy technician sent a task to the mental health team that Mr Iverson was "slipping backwards", hearing voices, refusing his medication and

requesting sleeping tablets. This was not actioned. The next day the pharmacy technician raised her concerns directly with a nurse during the multidisciplinary meeting. Again, no action was taken.

122. The Deputy Head of Healthcare said that a nurse should have gone to see Mr Iverson on 9 May. She said that the nurse had told her that she had decided to leave this follow-up for the mental health team manager who was working the following day, since Mr Iverson had previously been on her caseload. The Deputy Head of Healthcare said that this issue had been addressed with the nurse as a performance management issue, as well as with the wider team generally.

123. It is unfortunate that there is no documentary evidence of the emails sent to the mental health team. However, messages were also passed to the team verbally and in person, in the weeks and days before Mr Iverson died. Given the strong recent link between Mr Iverson's auditory hallucinations and risk to himself, these concerns should have been acted on urgently. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **prisoners are appropriately discharged from mental health services;**
- **all staff are aware of how to appropriately refer prisoners or pass relevant information to the mental health team and other healthcare staff;**
- **concerns passed onto the mental health team are appropriately managed and all significant information is documented in a prisoner's clinical record, and/or passed onto the relevant medical professional; and**
- **mental health staff assess prisoners in line with guidelines and offer follow-up appointments where necessary.**

Secondary health screen

124. Mr Iverson's secondary health screen took place four months after he arrived at Woodhill, rather than within the target of seven days. The Deputy Head of Healthcare said that there was a backlog of secondary health screens when Mr Iverson was at Woodhill. However, this has now been cleared by allowing other healthcare staff, not just nurses, to complete the screenings. We therefore make no recommendation on this.

Medication compliance

125. Mr Iverson was not compliant with some of his prescribed medication, most notably his antipsychotic and antidepressant medication. The Deputy Head of Healthcare told the investigator that if a prisoner does not collect their medication, the reason for this should be followed up and recorded. This was particularly the case for antipsychotic medication, which is regarded as a critical medication.

126. The clinical reviewer concluded that Mr Iverson's non-compliance with his medication was not adequately recorded in his clinical record, nor were the

mental health team kept adequately informed of his non-compliance. We make the following recommendation:

The Head of Healthcare should ensure that refusal and non-compliance with medication is documented in a prisoner's clinical record, in addition to the medicine administration record. In particular, the mental health team should be informed if prisoners refuse antipsychotic medication.

Bullying

127. Mr Iverson's next of kin said that Mr Iverson had told her that other prisoners called him derogatory names and bullied him because of the nature of his offence. Mr Iverson told staff in November and December that he was being threatened by other prisoners but did not give any names. Staff submitted intelligence reports as they were required to do. Sometimes, when Mr Iverson was subject to constant observations, he said he felt in fear of others. However, he was also known to be having auditory hallucinations and psychotic symptoms and was paranoid at the time. It was therefore very difficult for staff to know the extent to which Mr Iverson's concerns were affected by his mental health.

128. In any event, Mr Iverson never gave any names of prisoners to staff for them to investigate. In addition, during the last few months of his life, staff believed he was more settled on the house unit, and he told staff he hoped that others accepted him, regardless of his offence, due to being located on the vulnerable prisoners' house unit.

Allegations against staff

129. Mr Iverson's next of kin said that Mr Iverson had told her that he thought his ribs were broken after staff had thrown him to the floor. He also told her that he thought his hand was broken. There is no reference to any such injuries in Mr Iverson's clinical record. At the end of January, it is noted in his ACCT caremap that he thought he had a hand injury. Staff referred him to a nurse and he saw medical professionals several times around this time but did not disclose any information about a hand injury. There is also reference to these alleged injuries in his intelligence record following an interview Mr Iverson had with a professional from an armed forces charity.

130. Mr Iverson was threatening towards officers on 13 February, which resulted in him being restrained, which may have involved him being on the floor. He did not make any complaint about this at the time. However, there is no record in Mr Iverson's clinical record that he was assessed by healthcare staff following the restraint as he should have been. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners are assessed by healthcare staff after being restrained.

131. The only reference to Mr Iverson alleging that officers had assaulted him was when he submitted a complaint on 31 March. The prison police intelligence officer responded to this complaint indicating that Mr Iverson needed to report it to the police with more specific information, including dates and names of staff, if he wanted to pursue the allegation.

132. In one of Mr Iverson's notes found when he died, he alleges that staff had mentally tormented him. He also included the epaulette numbers of several members of staff although it is not clear why. The investigator spoke to the Deputy Governor about some of the members of staff identified. She had considered the evidence and had no concerns about staff. The investigator also did not establish any cause for concern in this regard.

Support for staff and prisoners

133. Most of the staff we spoke to said they had felt adequately supported after Mr Iverson's death. However, some staff who had had ongoing contact with Mr Iverson and were not involved in the emergency response said that no one had checked on their welfare immediately after Mr Iverson died.

134. We only spoke to two prisoners about Mr Iverson's death but one of those we spoke to said he had requested support from a mental nurse but was still waiting to see them. We make the following recommendation:

The Governor should ensure that staff and prisoners are offered appropriate support following a death in custody or other traumatic event.

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