Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ellis Wood, on 24 November 2023, following his release from HMP Lincoln

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. 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.

2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

4. Mr Ellis Wood died of tramadol toxicity in combination with diazepam, ketamine, pregabalin, promethazine and zopiclone, on 24 November 2023, following his release from HMP Lincoln on 21 November. He was 33 years old. We offer our condolences to those who knew him.

5. Mr Wood had a history of substance misuse and did not always engage with community drug and alcohol services. As a result of his non-compliance, he was recalled to prison in October 2023. Immediately before he returned to prison, Mr Wood was admitted to hospital following an apparent drugs overdose.

6. The manager of the substance misuse service at Lincoln told us that Mr Wood should have been offered a naloxone kit (to reverse the effects of opiate overdose) on his release from prison. There is no evidence that he was offered it and he was evidently a clear candidate for it. The Head of Service Delivery (Substance Misuse) will wish to review the circumstances of Mr Wood's release to identify whether there was a process failure.

The Investigation Process

7. We were notified of Mr Wood's death on 27 November 2023.

8. The PPO investigator obtained copies of relevant extracts from Mr Wood's prison and probation records.

9. We informed HM Coroner for Rutland and North Leicestershire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's office contacted Mr Wood's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Wood's father later contacted us about the investigation. Mr Wood's parents both asked how probation staff had managed Mr Wood after his release from prison.

11. Mr Wood's parents received a copy of the initial report. Mr Wood's mother raised one factual inaccuracy which has been addressed in this report. Mr Wood's father raised some further concerns about how probation managed Mr Wood in the community which have been addressed in this report and through separate correspondence.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Lincoln

13. HMP Lincoln holds remanded and convicted men, in four residential wings. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. Nottinghamshire Healthcare NHS Trust provides health services with 24-hour nursing cover. It also provides substance misuse services,

Probation Service

14. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

15. The last HMIP inspection at HMP Lincoln was in January 2020. Inspectors found that, despite a high level of need, the integrated mental health team provided a very good and accessible service, which delivered a wide range of evidence-based therapies. Drug and alcohol dependent prisoners were very positive about the care they received. Their treatment was prompt and met individual need. Psychosocial support was generally good. Inspectors also found that post-release support was good.

Key Events

16. On 29 July 2020, Mr Ellis Wood was remanded to HMP Leicester on drugs charges. He was later sentenced to six years in prison for possession with intent to supply Class A drugs and spent time in several prisons. Mr Wood was diagnosed with schizophrenia, depression and anxiety and had previously worked with community mental health services. Mr Wood also reported a history of substance misuse, including benzodiazepines and cannabis. Prison records indicated that Mr Wood tried to take his life in the community earlier in 2020. He was not monitored under suicide and self-harm prevention procedures (known as ACCT) before his release from prison.

17. On 4 July 2023, Mr Wood was transferred to HMP Fosse Way. On arrival, Mr Wood did not raise any concerns but accepted referral to the substance misuse team.

18. On 28 July, Mr Wood was released from Fosse Way on licence. He was supposed to live with a friend on release. At the time of his release, Mr Wood was prescribed olanzapine (an antipsychotic) and mirtazapine (an antidepressant). Before his release, he was referred to the community mental health team, and a community drug and alcohol support service. Healthcare staff offered Mr Wood naloxone (medication given as an injection to reverse the effects of opioid overdose) on release, which he declined as he said that he did not intend to use drugs.

19. Mr Wood's community offender manager (COM) told us that she first met Mr Wood in July 2023. She said that Mr Wood was randomly drug tested on 15 August, and the test came back positive for cocaine. Mr Wood self-reported using illicit medications, namely pregabalin and diazepam.

20. On 19 October, the COM processed Mr Wood's recall to prison. She said that Mr Wood was recalled following several attempts to engage with him due to his levels of substance use, which resulted in non-attendance or attending under the influence. Mr Woods was unlawfully at large between 19 and 26 October.

21. On 25 October, Mr Wood was admitted to hospital following a seizure. Healthcare staff later recorded that the seizure resulted from an overdose of his prescription medication. (It is unclear whether this was a deliberate or accidental overdose.) On the same day, Mr Wood was booked into HMP Leicester, and prison staff began a hospital bedwatch.

22. On 27 October, Mr Wood discharged himself from hospital and was therefore taken to prison. He declined to engage with his initial health screen. Healthcare staff recorded that Mr Wood arrived with olanzapine, mirtazapine, zopiclone (a sleeping tablet) and lansoprazole (for indigestion and stomach acid). They referred him to the mental health team. Prison staff started ACCT procedures.

23. On 28 October, Mr Wood agreed to complete his initial health screen. He said that he had experienced a seizure and that he had not taken an overdose of medication. Mr Wood took a urine drugs screen, which was positive for benzodiazepines and cannabis. He also said that he used cocaine around once a month, and pregabalin (medication for epilepsy) every day. Healthcare staff prescribed pregabalin and a decreasing dose of diazepam, to allow Mr Wood to withdraw safely from

benzodiazepines. (Mr Wood continued to follow this programme after his transfer to HMP Lincoln.)

24. That day, at an ACCT case review, Mr Wood said that he had no thoughts of self-harm but that he was "hearing voices" that were "threatening and horrible".

25. On 1 November, a mental health nurse assessed Mr Wood and recorded that he spoke about hearing voices and thoughts that other people were talking about him or that people were poisoning his food. Following discussion, mental health team staff referred Mr Wood for a psychiatrist review.

26. On the same day, the OMU duty probation worker gave Mr Wood a 28-day recall pack, which Mr Wood signed. They did not record any concerns for Mr Wood.

27. At an ACCT case review that same day, Mr Wood said that he was sleeping better and engaging with others. He said that he had regular contact with his family and had hopes of getting back in contact with his daughter when he was released. Mr Wood said that he had no thoughts of self-harm or suicide. Prison and healthcare staff agreed to close the ACCT procedures.

28. On 3 November, Mr Wood was transferred to HMP Lincoln. He told healthcare staff on arrival that his mental health was "okay". They referred him to the mental health team. The local substance misuse support service, We Are With You (WAWY) also saw Mr Wood following his arrival at Lincoln.

29. On 8 November, Mr Wood attended an ACCT post closure review, at which he said he was "good" and reported no concerns.

30. On 14 November, a psychiatrist assessed Mr Wood. The psychiatrist did not record that any follow-up care was required.

31. On 21 November, Mr Wood was released from prison on licence. He was prescribed discharge medication consisting of pregabalin, lansoprazole, olanzapine and mirtazapine. The manager of WAWY told us that Mr Wood would have been offered naloxone when he was discharged. There is no record of whether this was offered or whether he accepted it. Mr Wood was referred to Turning Point (a community organisation that provides drug and alcohol and mental health support)

32. The COM told us that Mr Wood was released to the same address at which he had previously lived. She checked with the police and the address was assessed as suitable.

Post release

33. On the day of his release, Mr Wood met his COM for an induction meeting. She told us that this was the only time she met Mr Wood after his release and prior to his death. She planned to meet Mr Wood again on 27 November, for a longer interview to discuss his sentence planning.

34. On 23 November, the COM received a phone call from the police, who said that Mr Wood was not living at the approved release address. She told us that she believed it likely that Mr Wood was residing at his mother's address, as he had previously

proposed this as a release address. (Following police input, this address had not been considered suitable for Mr Wood because of the risk he posed to other family members.)

35. On 24 November, following discussion with her manager, the COM called Mr Wood's mother to get further information. Unfortunately, this occurred while paramedics were attending to Mr Wood.

Circumstances of Mr Wood's death

36. On 24 November, Mr Wood's mother found him unresponsive in bed. She called the ambulance service. Paramedics attended and pronounced Mr Wood dead at 12.47pm.

Post-mortem report

37. The post-mortem report concluded that the cause of death was tramadol toxicity in combination with diazepam, ketamine, pregabalin, promethazine, and zopiclone.

Support for staff

38. The COM said her manager offered her support following Mr Wood's death, including through professional wellbeing services, and was supportive in the days afterwards.

Contact with Mr Wood's family

39. Mr Wood's mother was his next of kin and called the ambulance after he was found in bed unresponsive.

Findings

40. Mr Wood had a history of substance misuse in the community and had recently overdosed on his prescribed medication, resulting in a hospital admission. While he engaged with substance misuse services in prison, he did not always engage with community drug and alcohol team, which ultimately led to his recall to prison in October 2023. He was referred to a community drug and alcohol service at the time of his release in November 2023, but died before he had the opportunity to work with them.

41. The manager of the substance misuse service at HMP Lincoln told us that Mr Wood "would have been offered" a naloxone kit when he was released. However, there is no evidence that this was offered to Mr Wood, or whether he declined or accepted it. The circumstances of Mr Wood's recall to prison indicate that he was particularly vulnerable to overdose and was a clear candidate for naloxone on release. The Head of Service Delivery (Substance Misuse) will wish to review the circumstances of Mr Wood's release to ensure that the processes for issuing naloxone to prisoners on release are robust.

Inquest

42. The inquest into Mr Wood's death concluded on the 27 August 2024. The coroner confirmed that Mr Wood's death was drug related.

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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