Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ashley Wood, a prisoner at HMP Exeter, on 9 September 2021

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

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 Ashley Wood died on 9 September having been found hanging in his cell two days earlier at HMP Exeter. Mr Wood was 26 years old. I offer my condolences to Mr Wood's family and friends.

Mr Wood was subject to Prison Service suicide and self-harm support measures (known as ACCT) when he died. However, I have concerns that these measures were not managed appropriately, Mr Wood's escalating risk was not adequately assessed and there were severe failings in the recording and communication of information relevant to Mr Wood's risk. I am also concerned that the risk Mr Wood perceived from others was not appropriately managed, nor were sufficient wellbeing checks carried out in line with Exeter's policy.

The clinical reviewer concluded that Mr Wood's clinical care was not equivalent to that he could have expected to receive in the community and identified several shortcomings in his care. These included a lack of mental health support, clinical observations not being done, referrals to the mental health team not being completed properly and Mr Wood's learning disability not being appropriately assessed and managed.

I have expressed concerns to the Governor of HMP Exeter and to the Prison Group Director for Devon and North Dorset about deficiencies in ACCT procedures in previous investigations at Exeter and it is troubling that I have had to raise these issues again in this report.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

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Summary

Events

1. On 21 October 2020, Mr Wood was sentenced to 18 months imprisonment for offences including assault. He was taken to HMP Exeter. It was his first time in prison. A GP continued Mr Wood's prescription of antidepressants. On 11 December, Mr Wood transferred to HMP Channings Wood.

2. On 16 July 2021, Mr Wood appeared at court for further assault charges and was remanded in custody. He was taken to Exeter. During his time at Exeter, Mr Wood felt threatened by other prisoners and wanted to transfer back to Channings Wood. On 29 July, Mr Wood cut his face and staff started ACCT measures. On 2 August, a GP stopped Mr Wood's antidepressant medication and prescribed him propranolol to try to lessen his feelings of paranoia and anxiety. On three separate occasions, Mr Wood said that he had symptoms of Covid-19 and self-isolated. All tests were negative, and staff thought that he may have been isolating due to feeling threatened by other prisoners.

3. Staff continued to review his ACCT regularly and noted that he should be referred for a Challenge Support and Intervention Plan (CSIP – to manage those at risk from or a risk to others). On 6 August, Mr Wood tied a ligature round his neck. On 7 August, Mr Wood moved to B wing which was for vulnerable prisoners. He continued to worry about leaving his cell although staff said that over time he began to settle. On 13 August, Mr Wood was sentenced to a further three years' imprisonment.

4. On 25 August, staff closed Mr Wood's ACCT. This was reopened on 28 August when Mr Wood self-harmed by cutting his arm. Towards the end of August, staff informed Mr Wood that all B wing prisoners were moving to A wing while B wing was refurbished. Mr Wood was very anxious about this and on 30 August tied a ligature around his neck.

5. On 3 September, all B wing prisoners moved to the fourth landing of A wing (A4). That evening, Mr Wood superficially cut his throat. On 4 September, he told a chaplain that he had tied a ligature the night before. That evening, he told staff that he had swallowed four vials of vape solution. Healthcare staff observed him for signs of toxicity. Mr Wood was due to transfer to Channings Wood on 9 September.

6. On 6 September, Mr Wood tied a ligature around his neck in the evening. Staff responded, radioed an emergency code, removed the ligature and spoke to him. A supervising officer (SO) increased his observations to hourly. The next morning a nurse assessed Mr Wood as he said he was having chest pain. He told her that he was hearing voices and had been banging his head. During the morning, he told staff that he was scared for his life.

7. At 11.13am, an officer found Mr Wood tying a ligature to his bed. Staff responded and removed the ligature. A nurse spoke to Mr Wood as he had chest pains but said she was unaware he had tied a ligature. In the afternoon, a mental health nurse assessed Mr Wood, but she was also not aware of the recent ligatures Mr Wood had tied. He told her he felt under threat from other prisoners. At 4.46pm,

staff found Mr Wood collapsed and unresponsive in his cell. Staff went into his cell, and he started to respond. A nurse assessed him and had no concerns that he was a risk to himself.

8. That evening, Mr Wood complained of chest pains on two separate occasions. Officers said they would alert healthcare staff but there is no evidence that they did so. At 7.33pm, an officer found Mr Wood hanging in his cell. They cut him down and began chest compressions. Paramedics took him to hospital and Mr Wood was placed on life support. On 9 September, hospital staff withdrew this life support and he died at 1.11pm.

Findings

9. Mr Wood was subject to ACCT measures from 29 July until he died, apart from a period of three days. We have concerns that consistent case managers did not chair ACCT reviews, immediate ACCT reviews did not take place after Mr Wood self-harmed or tied a ligature, his family were not involved in the ACCT and the ACCT review scheduled for 7 September did not take place. It is also concerning that staff did not adequately record, communicate and assess Mr Wood's increasing risk on 6 September and 7 September. We recommend that staff need further ACCT training.

10. Mr Wood felt at risk from other prisoners after he returned to Exeter. Despite staff indicating they would do so, he was never referred for a CSIP. It seems likely that Mr Wood's fear increased when the vulnerable prisoners' wing was temporarily relocated to the top floor of a standard wing, and we are not convinced that his feelings of being threatened were adequately explored or dealt with.

11. The clinical reviewer concluded that Mr Wood's clinical care was not equivalent to that he could have expected to receive in the community. He should have had access to mental health support, mental health referrals sometimes did not follow the correct process, clinical observations were not carried out as directed and his learning disability was not adequately assessed or planned for.

12. Mr Wood should have had daily wellbeing checks during the Covid-19 pandemic as he was considered a risk to himself. These took place on less than half of the days that they should have.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
    - a named consistent case manager chairs ACCT reviews;
    - staff hold an urgent case review when a prisoner's risk increases;
    - a prisoner's family and friends are included in the ACCT process where appropriate;
    - staff hold ACCT reviews as scheduled;
    - staff appropriately question prisoners following an incident of self-harm or attempted suicide; and
    - staff record and share all information that affects risk.

- The Governor should ensure that prison staff inform healthcare staff when a prisoner asks to see them.
- The Governor and Head of Healthcare should ensure that all staff have received full (two day) ACCT training and that they are satisfied that staff can appropriately assess a prisoner's risk to themselves.
- The Governor should ensure that incidents of violence, bullying or intimidation are investigated and dealt with in line with local and national policies.
- The Head of Healthcare should ensure that those who are on a waiting list for therapy have access to mental health support in the interim if there is a risk of suicide and self-harm.
- The Head of Healthcare should ensure that:
    - when a prisoner needs clinical observations these are completed; and
    - staff refer prisoners appropriately to the mental health team.
- The Head of Healthcare should ensure that all prisoners with learning disabilities are clearly recorded, staff receive relevant learning disability training and follow NHSE/I guidance for prisoners with learning disabilities.
- The Governor should ensure that the key worker scheme is properly embedded and that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role.
- The Governor and Head of Healthcare should ensure that this report is shared with all staff named in it and that they are given the opportunity to reflect on the learning involved.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

14. Due to the COVID-19 pandemic, the investigator was unable to visit the prison. She obtained copies of relevant extracts from Mr Wood's prison and medical records via email.

15. NHS England commissioned a clinical reviewer to review Mr Wood's clinical care at the prison. The investigator and clinical reviewer interviewed 17 members of staff and three prisoners via telephone and video conference.

16. We informed HM Coroner for Exeter and Greater Devon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Wood's stepmother and daughter, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Wood's stepmother asked the following questions:

    - Why had Mr Wood's co-defendant been allowed to make false allegations about the nature of Mr Wood's offence?
    - Why was Mr Wood's co-defendant transferred before him?
    - Why were Mr Wood's suicidal thoughts not taken seriously? Was he on an ACCT? If he was on an ACCT, how could he take his own life? How often was he being checked?
    - If the prison knew Mr Wood had suicidal thoughts, why was he allowed razors?
    - Did Mr Wood have a safeguarding plan and, if so, what was on it?
    - Why was Mr Wood not transferred to HMP Channings Wood on 17 August when his family had been informed he would be?
    - Why was Mr Wood's family not told when Mr Wood cut his arms and neck or had suicidal thoughts?
    - Was Mr Wood "spiked", bullied or exploited for sexual activity?
    - Can Mr Wood's cellmate when he first went to Exeter be interviewed?

18. Our investigation found no evidence that Mr Wood took illicit drugs or drank alcohol with or without his own consent or that he was exploited for sexual activity. We have not interviewed Mr Wood's previous cellmate since he was in a single cell for around the last month of his life. Staff confirmed that Mr Wood was allowed to have razors and that such items would only be restricted if he was assessed as being a very high risk to himself, which he was not. Prison Service policy indicates that

unnecessary removal of such items can have a detrimental effect by increasing a prisoner's distress and risk.

19. We interviewed Mr Wood's co-defendant and he denied making any false allegations about the nature of Mr Wood's offences. During a telephone call to his family, Mr Wood also said that this was the case. All of Mr Wood's family's other questions have been addressed in the report.

20. Mr Wood's daughter received a copy of the draft report and indicated that they were satisfied with the findings.

21. Mr Wood's stepmother family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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

Background Information

HMP Exeter

23. HMP Exeter holds up to 431 adult men and young offenders, and serves the courts of Devon, Cornwall and Somerset. GP and primary care health services are delivered by Practice Plus Group (PPG), formerly known as Care UK. Devon Partnership NHS Trust provide mental health services and substance misuse services are provided by PPG and EDP Drug and Alcohol Services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Exeter was in March 2021. Inspectors reported that there was a high turnover of staff at all levels and one-third of frontline staff had been in post for less than a year. They found that more progress was needed to create a safer, more decent and secure prison. Inspectors noted that relationships between prisoners and staff were not good enough.

25. Inspectors found that there had been little progress in addressing long-standing deficiencies in the care of prisoners at risk of suicide and self-harm. Levels of self-harm had increased during the pandemic and were very high. Inspectors found that the quality of many ACCT documents was poor. They noted that most caremaps contained basic actions but few of these had been completed. Inspectors found that there were also limited opportunities for prisoners at risk of self-harm to have meaningful interaction with staff. Conversations with prisoners on ACCT took place each day but most were conducted through doors and lacked privacy and depth. They found that case reviews were timely, but healthcare staff often were not present. Inspectors found that there was a well supervised safer custody telephone line for people to call if they had concerns about a prisoner.

26. Inspectors concluded that healthcare provision was reasonable and access to clinics was improving. Inspectors found that the provision of medicines was managed well.

27. HMIP found that prisoners' perceptions of safety were poor with 29% feeling unsafe at the time of the inspection, 24% said that they had experienced bullying or victimisation from other prisoners and 41% said they had experienced bullying or victimisation from staff.

28. Inspectors reported that for most prisoners, time out of their cell was limited to around 90 minutes per day and less at the weekends.

Independent Monitoring Board

29. 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 December 2021, the IMB reported that the prison's response to Covid-19 had been generally well managed. However, they noted that several prison processes and programmes had suffered. They noted the high proportion of newly appointed officers, the difficulty of retraining

staff and staff doing extra hours to cover shifts resulting in some staff fatigue. The IMB noted levels of self-harm and violence remained high. They noted that there was clear evidence that the prison was committed to reducing violence and self-harm but there was still scope for improvement.

30. The IMB concluded that staffing problems in healthcare had coincided with the need to manage the pandemic. Some healthcare appointments had been restricted to urgent care and medications only, although GP appointments continued via the telephone.

31. The IMB noted that the refurbishment of B wing (which housed vulnerable prisoners) and their temporary relocation to A wing had created a number of practical challenges for prisoners some of which had impacted on their perceptions of safety and opportunities. They noted that when the B wing prisoners moved, a secure gate had not been fitted to prevent access to A4 landing by other A wing prisoners. (Although the prison clarified that an officer was stationed at the entrance to A4 landing to prevent other prisoners accessing the landing.) Mr Wood was located on A4 landing when he died.

Previous deaths at HMP Exeter

32. Mr Wood was the ninth prisoner to die at Exeter since September 2019. Three of these previous deaths were self-inflicted and five were due to natural causes. In all three self-inflicted investigations, we have identified the need for improvements in risk assessment and ACCT management (although one of these is still subject to investigation). We also requested a meeting with the Prison Group Director for Devon and North Dorset so that they could outline what they were doing to improve the management of prisoners at risk of suicide and self-harm. Two previous investigations also found that improvements were needed in investigating and dealing with incidents of violence, bullying or intimidation. There has been one self-inflicted death at the prison since that of Mr Wood which we are currently investigating.

Assessment, Care in Custody and Teamwork

33. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

34. As part of the process, a care plan is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*.

COVID-19 restrictions

35. On 24 March 2020, in response to the COVID-19 pandemic and in line with Government advice, HMPPS issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected Government restrictions following the national lockdown of 23 March. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent much of their day locked behind their cell doors.

Keyworker scheme

36. The keyworker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversation which each of their allocated prisoners.

    The keyworker scheme was suspended across the estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, such as those who were at risk of suicide or self-harm, the Prison Service introduced the Exceptional Delivery Model for keywork in May 2020. This provides that an officer will have a weekly conversation with prisoners identified as vulnerable.

Key Events

HMP Exeter, 21 October 2020 – 11 December 2020

37. On 21 October 2020, Mr Wood was sentenced to 18 months imprisonment for assault, causing animal suffering and possession of an offensive weapon and taken to HMP Exeter. It was his first time in prison. Mr Wood told a nurse that he had previously self-harmed by cutting himself in March but had no current thoughts of suicide or self-harm. He said he suffered from anxiety and depression and was referred to the mental health team. Mr Wood said he misused alcohol, his withdrawal symptoms were assessed, and he was prescribed medication to try to lessen these.

38. On 24 October, a nurse from the mental health team assessed Mr Wood. He said that he wanted to be transferred to HMP Channings Wood as he had heard positive reports about it. He said he had previously been prescribed citalopram (an antidepressant). A GP later prescribed him citalopram and planned to review his mood in three weeks. Mr Wood declined psychological support as he did not feel it was the right time for him.

39. On 10 November, a GP reviewed Mr Wood's mood and doubled his prescription of citalopram. On 1 December, a GP noted that Mr Wood had a possible diagnosis of a learning disability and that this had not been addressed in his recent mental health assessment. They sent a referral to the learning disabilities team.

40. On 7 December, Mr Wood told staff that he had chest pain. Healthcare staff assessed him and had no concerns. Mr Wood then said he needed paracetamol for toothache. Nurses told him they could not give him the medication. Mr Wood cut himself with a razor. Staff started Prison Service suicide and self-harm support measures, known as ACCT. Healthcare staff assessed Mr Wood, and he was given paracetamol and ibuprofen.

41. During the ACCT review later that day, Mr Wood told staff that his toothache had been so acute that he had felt like he had no other option but to self-harm. He said he had no current thoughts of suicide or self-harm. Staff closed Mr Wood's ACCT and a senior prison manager investigated why Mr Wood had not originally been given his pain medication.

42. On 8 December, Mr Wood's cellmate assaulted him, and he sustained facial injuries. Healthcare staff assessed him and observed him regularly. Mr Wood was also assessed by staff from the learning disabilities team. He said that he was dyslexic but was unaware of any diagnosis of a learning disability. Staff noted that they did not assess he had a learning disability but noted that he was somewhat naïve and could be potentially vulnerable to exploitation and bullying.

HMP Channings Wood, 11 December 2020 – 16 July 2021

43. On 11 December, Mr Wood transferred to Channings Wood. He progressed well at the prison, engaged with substance misuse services, enrolled in education and worked intermittently. In January 2021, it was documented that Mr Wood had a diagnosis of second-degree heart block (a condition which causes the heart to skip

beats). The clinical reviewer noted that this has a range of clinical consequences but was not a concern for Mr Wood and did not require any ongoing treatment. Symptoms can include chest pain, fainting and dizziness.

44. In February and April, Mr Wood said he had chest pain. Healthcare staff and paramedics assessed him and concluded that it was anxiety related. Mr Wood had been working towards his release on 21 July. However, he became concerned that he might be facing further charges.

45. On 13 June, a nurse from the mental health team assessed Mr Wood after he had referred himself. He told them that he was expecting further charges and thought he would be remanded to HMP Exeter. He said he had suffered from anxiety for years, had heart palpitations, struggled with his breathing and his body ached. He said he struggled to get out of bed some days and had low motivation. Mr Wood said that he had taken an overdose two years ago. Due to Mr Wood's planned release the following month, he was not added to their caseload.

46. On 25 June, Mr Wood was due to appear at court on new charges. He refused to attend. On 8 July, staff from the mental health team saw Mr Wood at his request. He said he had felt increasingly anxious over the previous month, felt low in mood but had no thoughts of suicide or self-harm. The nurse said that she would speak to the team and noted that he might benefit from attending the anxiety group. She also advised him to speak to the GP about his medication.

47. On 12 July, a nurse assessed Mr Wood who said he felt anxious about his court hearing that week. He said he had chest pains which healthcare staff assessed. On 14 July, staff did an ECG which showed abnormalities and Mr Wood was taken to hospital for further investigation. There is no discharge summary in Mr Wood's record to detail the conclusion of this assessment.

48. On 16 July, Mr Wood attended court and was remanded to custody on further assault charges. Mr Wood's co-defendant was also remanded to custody that day. He told the investigator that Mr Wood seemed anxious in court. He said that they had regularly spoken on the telephone before the court date and that Mr Wood had seemed "bright". He never had any concerns that he was a risk to himself.

HMP Exeter, 16 July 2021 onwards

C wing

49. Mr Wood was taken to Exeter and located on C wing, a standard residential wing. On 20 July, a GP prescribed him citalopram after staff realised he had not brought this medication with him from Channings Wood. The GP also referred him for an ECG which was due to take place on 25 July. This did not go ahead, and it is not clear why. On 28 July, Mr Wood met with his key worker. He said he wanted to be sentenced and return to Channings Wood.

50. On 29 July, around 7.00am, Mr Wood gave a note to staff to say that he felt his life was in danger due to rumours about him and he would like to be moved to B wing, where the vulnerable prisoners (those that are considered to be at risk from other prisoners) were located. He said other prisoners were calling him a "nonce" and

threatening to stab him. At 1.20pm, Mr Wood made superficial cuts to his face with a razor blade. Staff opened an ACCT. Healthcare staff assessed him, and he was referred to the mental health team

51. On 30 July, an officer completed Mr Wood's ACCT assessment. Mr Wood said that he felt anxious, and his antidepressants were not working. He said that he had been too scared to leave his cell due to being threatened by other prisoners (but would not give any names) and had not been eating. During the subsequent case review chaired by a Supervising Officer (SO), staff present reduced Mr Wood's observations. The SO told the investigator that those present thought opening a Challenge Support Intervention Plan (CSIP – used to support prisoners at risk from or a risk towards others) might be more appropriate than an ACCT and noted that they would refer him.

52. A nurse noted that Mr Wood had his medication in his own possession, but he had not collected this since arriving at Exeter. The nurse sent a task to the pharmacy team to review him and check his cell for medication. She also changed Mr Wood's medication to not in his possession since he was on an ACCT.

53. A nurse from the mental health team had been present in the ACCT review and assessed Mr Wood afterwards. He said he wanted to try different medication as he thought the citalopram was not working and felt anxious. There is no record that she discussed this may have been because Mr Wood had not been taking his citalopram.

A wing

54. On 1 August, Mr Wood moved to A wing. There is also a note in his record that a SO was going to do a CSIP referral. There is no record that this was done.

55. On 2 August, Mr Wood's sister rang the prison. She said she was concerned about Mr Wood who said that he was going to hang himself. Staff carried out a welfare check and a SO increased Mr Wood's ACCT observations to hourly.

56. During a multidisciplinary meeting that day, healthcare staff agreed Mr Wood would start psychological therapy once transferred to Channings Wood. A prison GP subsequently assessed Mr Wood and noted he showed no signs of depression but was anxious. She stopped Mr Wood's prescription of citalopram and prescribed him propranolol to try to lessen his feelings of paranoia and anxiety. Mr Wood told staff that he had a sore throat and had lost his sense of taste and smell. He self-isolated and was tested for COVID-19 (which was negative a couple of days later).

57. On 3 August, during an ACCT case review chaired by a SO, Mr Wood told staff that he still felt threatened on A wing and was waiting for a response to his application to be a vulnerable prisoner.

58. On 6 August, during a case review, Mr Wood again said that he had Covid-19 symptoms and he self-isolated. Staff noted that they had not witnessed anyone threatening him nor had his cellmate, but Mr Wood said that he was "absolutely terrified" of leaving his cell. He still wanted to move to B wing. The SO noted that he was being considered for a CSIP which they considered would have been more

appropriate than an ACCT. Mr Wood said that he had no thoughts of suicide or self-harm.

59. At 11.40pm, Mr Wood's family telephoned the prison to say that he had just called them and told them he was going to tie a ligature. Staff went to Mr Wood's cell, who started to put his head through a ligature he had made. Staff went into his cell and removed the ligature and healthcare staff assessed Mr Wood. They noted faint marks on his neck but no other injuries. They referred him to the mental health team. He told staff that he wanted to move to B wing as prisoners were calling him names. Staff explained this was not possible as he did not meet the criteria and discussed other options. Mr Wood said he would self-isolate until he was sentenced after which he would apply for a transfer to Channings Wood. Mr Wood's ACCT observations were increased to three per hour.

60. Mr Wood's stepmother told police that the calls from Mr Wood became more worrying. He said he was under threat from prisoners and staff who he thought would stab him. She said that she telephoned the prison and asked them to put him under constant observation. They replied that they would assess and support him. She said that a few weeks before Mr Wood was sentenced, a SO called her and told her that Mr Wood would be transferred to Channings Wood on 17 August. She said that the SO had told her that he was going on leave, but Mr Wood would be transferred while he was away.

61. On 7 August, during an ACCT case review chaired by a SO, staff and Mr Wood discussed his plan to isolate until his court appearance on 13 August. They decreased Mr Wood's observations to hourly. A nurse from the mental health team spoke to Mr Wood after his ACCT review. Mr Wood said he was paranoid and anxious on A wing. He said he had no thoughts of suicide or self-harm and would speak to her the next day.

B wing

62. Mr Wood was not assessed as a vulnerable prisoner but at his request he moved to B wing (for vulnerable prisoners) in the afternoon of 7 August. A SO said that Mr Wood was unlocked with a small number of prisoners who were also on the vulnerable prisoners' wing but were not vulnerable prisoners themselves.

63. On 9 August, the mental health nurse assessed Mr Wood. He remained fearful of other prisoners and had been refusing to leave his cell. The nurse also noted that Mr Wood had not had the ECG which had been requested and this took place later that day. She referred him to a GP who later prescribed him sertraline (an antidepressant). Mr Wood was compliant with both his sertraline and propranolol medication.

64. On 10 August, during an ACCT case review chaired by a SO, Mr Wood said he felt safer on B wing and asked if he was going to be moved back to A wing. He was told this was not the plan. Staff noted that the mental health team had indicated that he was unlikely to be allocated to their caseload as he was only due to be at Exeter for a short time. On 12 August, a healthcare assistant from the mental health team went to see Mr Wood. They noted that Mr Wood was paranoid and dishevelled. Mr Wood later said that he had a sore throat and therefore self-isolated.

65. On 13 August, Mr Wood was sentenced to three years imprisonment for assault offences. He did not attend court as he was self-isolating. There is no evidence that staff informed him of the outcome despite it being listed in the triggers section of his ACCT document and him having mentioned this during ACCT reviews. Mr Wood told a nurse that prisoners from A wing were threatening him. The nurse noted that he had not yet been discussed at the weekly Multi-Disciplinary Team (MDT) allocation meeting.

66. Mr Wood's stepmother said that Mr Wood continued to call her daily with his mood fluctuating between paranoid and rational. However, between 13 August and 2 September Mr Wood was unable to call anyone due to an issue with the prison's telephone lines.

67. On 16 August, Mr Wood asked staff during an ACCT review what sentence he had received at court. There is no record that staff knew the outcome or that they informed him. A nurse discussed Mr Wood at the MDT meeting later that day. She told the investigator that because Mr Wood's transfer to Channings Wood had not happened as quickly as they had been expecting the MDT had agreed to refer him to a psychologist. A GP also reviewed Mr Wood's recent ECG and noted they had no concerns.

68. Prisoner A was on B wing at the same time as Mr Wood and shared a cell with his cousin. He had known Mr Wood since childhood. They were not unlocked for association at the same time, but he said that Mr Wood used to come to their cell to speak to them through the observation panel. He said that Mr Wood seemed depressed and was not himself. He said that Mr Wood was quite "feisty" in the community but in prison he seemed "deflated", "low" and lethargic. Mr Wood told the prisoner that he was worried that other prisoners thought he was a sex offender and were shouting abuse at him.

69. Staff told the investigator that Mr Wood was generally anxious while he was on B wing and often had to be encouraged to leave his cell. Staff said that over time staff built up trust with Mr Wood, so that he seemed more settled and less paranoid about other prisoners. At some point, Mr Wood was informed about the sentence he had received although this is not documented. A SO told the investigator that Mr Wood seemed fairly happy about the sentence and had been expecting three years.

70. On 18 August, Mr Wood had a key worker session. This took place at Mr Wood's cell door as he was self-isolating. Mr Wood said that when he stopped isolating, he would like to enrol in education and spoke about his release.

71. On 20 August, Mr Wood's most recent Covid-19 test came back as negative. Around 5.00pm, he said that he had chest pain. A nurse assessed him, his observations were normal, and they did an ECG which they sent to a GP for review. The nurse questioned whether the pains were anxiety related.

72. On 25 August, during an ACCT review, Mr Wood said that his medication had helped his anxiety, he was no longer isolating and was associating with other prisoners. He said he had no thoughts of suicide and self-harm, and staff closed his ACCT.

73. On 27 August, Mr Wood asked an officer if he could see the mental health team. A GP reviewed Mr Wood's recent ECG results. The GP concluded that the chest pain was probably musculoskeletal and prescribed codeine (a painkiller), requested blood tests, a repeat ECG, daily clinical observations and a follow-up review in a week. On 28 August, at 6.45pm, Mr Wood self-harmed by making superficial cuts to his arm. He said he did so as he felt unsafe on the wing. Staff reopened his ACCT.

74. During an ACCT review on 29 August, Mr Wood said that he had no intention of dying but was having suicidal thoughts and used self-harm as a coping mechanism. He said he did not want his medication increased. Staff noted that he had poor personal hygiene and still felt under threat on the wing.

75. On 30 August, staff found Mr Wood with part of a bed sheet wrapped around his neck and the other end tied to the pinboard holder. Mr Wood did not respond to staff, so they radioed a code blue (an emergency code indicating that a prisoner is not breathing or is having difficulty breathing) and went into the cell. Mr Wood got up and removed the sheet from his neck. Mr Wood said that if he was moved to a standard residential wing he would be killed. (Although it is not documented, it seems likely that staff had spoken to him about moving back to A wing while B wing was being refurbished). A nurse checked Mr Wood and mental health staff spoke to him. Staff increased his observations to hourly until he had an ACCT review the following day.

76. A nurse later reviewed Mr Wood and he said that he had tied the ligature over anxiety about moving back to the main wing where he would be under threat. He said he wanted to transfer to Channings Wood. On 31 August, healthcare staff did an ECG and took observations and blood for testing as previously requested by the GP. A GP reviewed the ECG results and concluded that there was evidence of possible heart block and tasked a nurse to complete further examinations. There is no evidence that further examinations took place.

77. During an ACCT review, staff confirmed that all prisoners on B wing had to move to A wing at the end of the week as B wing was closing for refurbishment. Mr Wood said that he might self-isolate until his transfer to Channings Wood but could not provide any names of prisoners from whom he was under threat. A SO spoke to the transfer clerk who confirmed that Mr Wood was prioritised for transfer the following week.

78. On 1 September, healthcare staff discussed Mr Wood at the MDT and arranged him an appointment with a psychologist on 7 September. On 3 September, Mr Wood told staff that he was worried about moving to A wing, he would not be able to cope and was having thoughts of self-harm. Staff told the orderly officer in charge of the prison. A SO told the investigator that Mr Wood had been worried that he would not be kept with the vulnerable prisoners, but staff reassured him that he would be.

A wing

79. Later that day, Mr Wood moved to the fourth landing of A wing (A4). A wing is a standard residential wing, but the fourth landing had been designated for vulnerable prisoners while B wing was being refurbished.

80. Around 8.00pm, Mr Wood made superficial cuts to his throat as he was not happy on A wing. Healthcare staff cleaned and glued his wounds. His observations were increased to two per hour. A SO said that staff tried to reassure him and talk to him about his imminent transfer.

81. On 4 September, during an ACCT review at 8.50am, Mr Wood said that he was terrified about collecting his medication with other prisoners. Staff arranged for Mr Wood to be able to collect his medication on his own. He told staff he felt unsafe on A wing and other prisoners would be able to harm him. Staff tried to reassure him that this was not the case and he and the vulnerable prisoners would remain separated from the rest of the prisoners. Staff reflected that he would be transferring to Channings Wood early the following week and encouraged Mr Wood to focus on this. They noted that he was likely to isolate until he moved. His observations were set at five overnight and one conversation in the morning and afternoon.

82. A member of chaplaincy staff went to see Mr Wood around 10.00am. He said he felt unsafe, and two prisoners had banged on his door the day before, told him he owed them money and he should pay, or they would "do him in". Mr Wood told the chaplain that that he had tried to tie a ligature last night. The chaplain noted that they told staff about their conversation, but did not note it in Mr Wood's ACCT.

83. Prisoner B was also a prisoner who was on B wing and then moved to A4 when it shut. He said that when they moved prisoners from other landings shouted towards the vulnerable prisoners, calling them derogatory names and saying things like "you all need to kill yourself". He said it did not happen all of the time but as soon as one prisoner started, others joined in. He said that this lessened after a short time, although it still happened sporadically. He never heard any threats or insults being directed specifically at Mr Wood.

84. At 11.50pm, healthcare staff assessed Mr Wood as he said that he had swallowed four vials of vape solution and had vomited blood. The GP advised staff that Mr Wood needed to go to hospital. However, the manager in charge of the prison at the time said that if Mr Wood went out to hospital it meant that they would not have sufficient staff if anyone needed emergency treatment. Healthcare staff decided to regularly observe Mr Wood overnight and the next day instead. Mr Wood's clinical observations remained stable that evening and there were no obvious toxicity symptoms. There is no evidence that these observations continued for the rest of the next day as planned.

85. On 5 September, Mr Wood worked with a group of prisoners on B wing to prepare it for the refurbishment. A SO deliberately included Mr Wood to get him out of his cell and socialising with other prisoners. The SO noted that he was happy working on B wing but was still anxious when he returned to A wing. The SO said that Mr Wood knew he was due to transfer to Channings Wood on 9 September and was looking forward to it.

6 September 2021

86. On 6 September, Mr Wood asked a member of staff if they could check if he was definitely moving to Channings Wood on 9 September. They said they would look into it for him. Mr Wood followed the regime and collected his food.

87. In the afternoon, Mr Wood asked to make a telephone call to request a GP appointment as his cell wall plug was not working. He spoke to a GP in the office on the telephone. He told her that he thought his new antidepressants were working better. He told the GP that he felt at risk from other prisoners and was looking forward to being transferred to Channings Wood. Mr Wood said that he had a heart issue and the GP noted that they needed to follow up the hospital for discharge information from the last time he Had been admitted.

88. A nurse administered the medication to prisoners on A4 landing at around 6.00pm. She said that when Mr Wood came to collect his medication, he asked if he could see her later that day. She said that she would try and see him once she had finished giving prisoners medication.

89. During the evening, Mr Wood told staff that he was scared of being on A wing. At 7.05pm, Mr Wood rang his cell bell and, when an officer attended, he was standing by his window with a ligature around his neck tied to the outer bars. The officer radioed for staff assistance and recorded that they cut the ligature. They noted in the ACCT document that Mr Wood's feet had remained on the floor throughout. Mr Wood said that other prisoners on A4 landing were calling him names. The officer no longer works for the Prison Service, so it was not possible to interview her.

90. Two nurses were both in the wing office when they heard the radio request for staff assistance. They went straight to Mr Wood's cell. Mr Wood was alert and conscious but had a red mark around his neck. Nurse A noted that there was a ligature made of torn bed sheet tied to the window bar which appeared frayed and another piece on the floor. The nurse told the investigator that she assumed that Mr Wood had put some pressure on it, and it had broken. She asked Mr Wood what had happened. Mr Wood said he was worried about being located on A4 landing and being at risk from other prisoners. The nurse tried to reassure him that prisoners from other landings could not gain access to A4. (At that time there was no gate separating the landings, but an officer guarded the stairs.) He also told the nurse that he was due to transfer to Channings Wood in a few days, but he could not wait to go there. Again, Nurse A tried to reassure him that it was only around two days until he would be there. Mr Wood then spoke to Nurse B, who also tried to reassure him and spoke to him about relaxation techniques.

91. A Custodial Manager (CM) was in charge of the prison that evening. When he heard that Mr Wood had tied a ligature, he went to his cell. He told the investigator that when he got there, the two nurses were talking to Mr Wood. Nurse B said that Mr Wood asked the CM if he could go onto constant watch or be in a safe cell. She said that the CM said that this was not necessary. The CM said that this conversation did not occur, and Mr Wood made no such request. The CM said that he tried to reassure Mr Wood that he was safe.

92. Nurse B asked Mr Wood if he was happy if a mental health nurse came to talk to him as she had to go and finish giving other prisoners their medication. He confirmed that he was happy with this. She said she left the cell when other staff were still in there to ring the mental health team. She tried to locate them, but they had left the prison earlier than scheduled (there should have been cover until 8.30pm). She did not refer Mr Wood to the mental health team. Neither nurse recorded the incident on Mr Wood's medical record or ACCT. Nurse A recorded the incident on the healthcare handover sheet by writing, "*ligature, not suspended*".

93. The CM asked a SO to review Mr Wood's ACCT observations. The SO said that when he went to see Mr Wood he was pacing in his cell. He was alone and the SO was aware that he had just tied a ligature in his cell. He did not notice any mark on his neck. The SO spoke to him about his anxieties and tried to reassure him that he was safe and prisoners from the landing below could not access A4. They spoke about Channings Wood and what it was like there. The SO scheduled an ACCT review for the next day and increased Mr Wood's observations to hourly.

94. The SO said that he did not think constant observation was necessary, since Mr Wood was a lot calmer by the end of their conversation and was focussed on the future. The SO spoke to the CM, and they were both satisfied that the increase in observations was appropriate. The CM recorded the information in Mr Wood's record and on a handover sheet for all staff to access the next morning. The SO returned later that evening to see Mr Wood who seemed calm and was in his bed.

Events of 7 September

95. On 7 September around 3.30am, Mr Wood told an officer that he had chest pain. A nurse assessed him and noted that Mr Wood was sitting on his bed and had no obvious symptoms of chest pain. He told her that he was hearing voices and had been banging his head. The nurse tried to reassure him that if he was anxious, it might help if he got some sleep. She noted that he appeared low in mood and "would try by all means to get to hospital". She told him to take some deep breaths and to keep himself occupied. She did not take any clinical observations. The nurse sent an email directly to a mental health nurse.

96. Wing staff spoke to Mr Wood during the morning. He told them that he felt dizzy and unwell, and he was scared for his life. He said that prisoners were saying they would "get him" and Mr Wood said, "I might as well do it myself before they get to me." Officers explained that they would keep him safe. Officer A told the investigator that Mr Wood often put himself down and questioned the point of him being alive. He tried to speak to Mr Wood about his family and plans for the future.

97. At 11.13am, Officer B found Mr Wood tying a ligature from a ripped piece of sheet that was tied to the top bunk of his bed with a loop the other end, but he had not put it round his neck. He informed another officer who was passing and stood outside his cell, and also told Officer A, who went to Mr Wood's cell within a minute. Officer B radioed Hotel 1 (the healthcare emergency responder) to come to Mr Wood's cell.

98. Officer A and Officer B gave the investigator conflicting accounts of what happened next. Officer B said that she went into the cell with Officer A and tried to talk to Mr Wood, but he did not really engage with them and seemed to be in a "daze". She said that the ligature was tied onto his bed, and they took it out of the cell.

99. Officer A told the investigator that Mr Wood denied that he had been making a ligature and that he had hidden it by the time she went into the cell. She said that another officer then came to the cell and she and Officer B told him that she had seen him make a ligature but that they did not know where it was. Officer A said that the other officer found the ligature and Officer B took it away. It has not been possible to identify the other officer.

100. Officer A said that Mr Wood was upset and paranoid that other prisoners were shouting at him and thought he was a sex offender. He said he felt threatened and unsafe. She said that she tried to reassure Mr Wood and tell him that he was safe. He also asked about his transfer to Channings Wood. She spoke to the chaplain and mental health team and asked them to see him. Both Officer A and Officer B knew that Mr Wood had tied a ligature the night before.

101. A nurse responded five minutes after Officer B had radioed for healthcare staff. Officer B said that she spoke to her and told her about the ligature. The nurse said that she was told that Mr Wood had chest pain and was short of breath. She said she was not told about the ligature.

102. The nurse assessed Mr Wood in his cell for around ten minutes. She said she could not take him to the clinic room as there was another prisoner in there being treated. He said that he was short of breath and had a tight chest and pain down his left arm. She checked his blood pressure and oxygen saturation which were both normal. The nurse told Mr Wood that she thought his symptoms were anxiety related but Mr Wood said this was not the case and that he had had heart problems in the past. She noted that staff should complete an ECG and the GP would be in the prison that afternoon and should review it. She told Mr Wood to use his cell bell if his symptoms got worse. She spoke to officers on the wing who were concerned and said that the mental health team would also try to assess him that day. She told the investigator that she did not have any concerns that Mr Wood was a risk to himself.

103. A SO said he went to Mr Wood's cell, and he was being spoken to by staff. He was unaware that Mr Wood had tied a ligature but was told he was anxious and having chest pains. He spoke to him briefly and said he was "very quiet".

104. At 12.00pm, Officer A moved Mr Wood to another cell across the landing because the telephone and water supply were not working in his current cell. Mr Wood had not had a telephone in his cell since moving to A wing but used the ones on the landing. She said that he seemed happy to be moving cells so that there was a telephone he could use. She locked him in his cell at 12.03pm.

105. The nurse later returned to the wing twice to do Mr Wood's ECG, but he was not in his cell. However, she was unaware at the time that Mr Wood had moved cells so was looking in the wrong cell. At 1.15pm, she spoke to another nurse to ask if she could go and see him as she felt that Mr Wood was anxious.

106. Officer A and Officer B did Mr Wood's ACCT checks that afternoon at 1.30pm, 2.15pm, 3.10pm and 4.15pm. Officer A said that during the afternoon Mr Wood said he had chest pains but did not seem to be in pain and she was concerned he may have been trying to get to hospital. Officer B said that throughout the day, Mr Wood remained paranoid and distant, and she tried to reassure him that he was safe. She said that she heard prisoners from the landing below shouting towards prisoners on A4, but that this was not directed specifically at Mr Wood. She said that when she answered his cell bell, he was concerned about what the prisoners were saying and that they were coming after him.

107. A healthcare assistant (HCA) went to collect Mr Wood for his ECG at 2.15pm, but he was outside having his exercise so she noted that she would return later.

108. Between 2.40pm and 3.40pm Mr Wood was let out of his cell for association. During this time, a nurse assessed Mr Wood. She told the investigator that she was not aware that Mr Wood had tied a ligature the night before or that morning. She noted that Mr Wood was stood just outside his door when she got there. They spoke in his cell. Mr Wood said that he felt under threat from other prisoners and thought that officers would unlock his door so that prisoners could assault him. The nurse tried to reassure Mr Wood and spoke about his transfer to Channings Wood. She told the investigator that Mr Wood was due to be assessed by a psychologist the following week and told him this.

109. Prisoner A also saw Mr Wood during this association time. He said that he seemed "quiet" but "alright".

110. Around 3.00pm, a probation officer spoke to Mr Wood on the landing to confirm that he would be transferred to Channings Wood on 9 September. Mr Wood said that he wished it could happen more quickly as he felt under threat from prisoners, and he was hearing voices telling him to kill himself. The probation officer thought that these were ongoing concerns which had been shared with staff before. He recorded the information in Mr Wood's ACCT. He said that he would contact the mental health team. However, he spoke to healthcare staff before he left the landing.

111. CCTV shows that during the afternoon, Mr Wood left this cell to use the kiosk on the landing, took part in exercise along with other prisoners and spoke to staff and prisoners on the landing.

112. The Head of Safety said that in the late afternoon, the TV boosters broke so that there was no TV in any of the cells on A wing. He said that this led to an increase in the noise on the wing, including prisoners shouting general abuse and kicking their doors.

113. At 3.39pm, Mr Wood rang his mother and spoke to her for 10 minutes. They spoke about his transfer the following week and plans for release. Mr Wood then spoke to his brother and said he had tried to hang himself the night before but would not do it again. Mr Wood said that other prisoners were threatening him and asking staff to get him out of his cell. Mr Wood's brother reassured him that this would not happen. They spoke about his transfer in two days, but Mr Wood said that he was scared he would not survive until then as other prisoners would harm him before that. Mr Wood said he would call him tomorrow.

114. At 4.18pm, Mr Wood rang his grandparents and spoke to them for 21 minutes. They discussed Mr Wood's medication. Mr Wood said his television was not working so he would find it difficult to sleep. Mr Wood said that he used to feel safe in his cell but did not anymore. His grandparents tried to encourage him about his imminent transfer.

115. At 4.42pm, staff unlocked Mr Wood's cell and he went to collect his evening meal, returning to his cell two minutes later. At 4.46pm, Officer A was walking past the cell, glanced in and then returned to Mr Wood's cell. Mr Wood was on the floor and appeared to be unresponsive. She shouted a code blue to Officer B, but neither officer had a radio. Other staff then radioed the code blue. Officer A went into Mr Wood's cell and tried to rouse Mr Wood by shaking him and calling his name and

put him in the recovery position. He then started to respond. She said Mr Wood seemed confused and asked what had happened.

116. At 4.48pm, a nurse responded and went into Mr Wood's cell with the emergency bag. She assessed Mr Wood, who was sitting on his bed when she got to the cell, alert and responsive. His observations were normal. She had no concerns that Mr Wood was a risk to himself. She ensured that Mr Wood had his ECG done as soon as possible. The nurse left the cell at 4.59pm, having spoken to a CM and Officer A.

117. At 5.00pm, Mr Wood left his cell to attend healthcare for an ECG. By this time, no GP was available at the prison to review it. A nurse (who had previously worked in cardiac care and had also seen one of Mr Wood's previous ECGs) reviewed the ECG and stated that there had been an improvement in the ECG since the previous reading two weeks ago and no urgent referral to the hospital was required. She requested that a prison GP should review the ECG the next day.

118. Mr Wood returned to his cell at 5.18pm. He briefly spoke to Officer A, who locked him in his cell.

119. At 5.18pm, Mr Wood rang his grandfather and spoke to him for 40 minutes. Mr Wood said that he had collapsed after getting his food. He said that he could not remember what had happened and had never fainted like that before. They discussed his release. At 5.25pm, Officer A and Officer B did a roll check. Both officers looked in through Mr Wood's observation panel.

120. At 6.00pm, Mr Wood rang his stepmother and mother, but neither answered their telephone. He then rang his brother, whom he spoke to for 31 minutes. Mr Wood said he still had no television. They spoke about his transfer and Mr Wood said that he still had to get through two nights at Exeter. He said that he still felt under threat from other prisoners. There was increasingly loud banging in the background of the telephone call.

121. Around 14 minutes into the call, Mr Wood rang his cell bell. An officer responded and the conversation can be heard on Mr Wood's telephone call. He told the officer that he was in "agony" with chest and rib pains and had collapsed earlier but these were new pains. He asked for aspirin or an ambulance. The officer asked Mr Wood to sit down and said she would ask healthcare staff what they could do. There is no evidence that the officer took further action to the request. The officer told the investigator that she could not recall this conversation.

122. Mr Wood remained on the telephone to his brother, they spoke about his release and transfer. Again, Mr Wood reiterated that other prisoners would harm him before he could be transferred. At 6.35pm, Mr Wood rang his mother and grandfather. Neither answered his call.

123. At 6.43pm, Mr Wood rang his grandfather and spoke to him and his other brother for around 23 minutes. Mr Wood said he was in "agony" and still had 60 hours to get through before being transferred as other prisoners wanted him dead. Towards the end of the call, Mr Wood started whispering and told his grandfather that officers had just let other prisoners out to kill him. His grandfather tried to reassure him. The call then cut out as Mr Wood's telephone credit had run out.

124. During the call, Mr Wood rang his cell bell. At 7.13pm, Officer B responded to this. Mr Wood said he had chest pain and asked to see healthcare staff. She told Mr Wood that she would speak to healthcare staff and see if they could provide some pain relief. This request was not passed on to healthcare. She told the investigator that she had planned to take Mr Wood to see healthcare once they had finished unlocking prisoners for medication. She said that she did not have any concerns that Mr Wood was a risk to himself as he was engaging with her and the person he was on the telephone to.

125. At 7.33pm, Officer C looked through Mr Wood's observation panel. He saw Mr Wood hanging by a ligature at the back of the cell. He immediately unlocked the door, while shouting to staff, and went into the cell with Officer A behind him. Officer C radioed a code blue. Officer D got to the cell a few seconds later. Officer C supported Mr Wood's weight while Officer D cut Mr Wood down with his anti-ligature knife. Mr Wood had used a bedsheet as a ligature tied to the window bars. Officer D removed the ligature from Mr Wood's neck and Officer C began chest compressions. Several more prison staff got to the cell within a few seconds. The officers took it in turns to do chest compressions.

126. At 7.34pm, a nurse arrived with the emergency equipment and defibrillator along with another nurse. More healthcare staff got to the cell shortly afterwards. Healthcare staff assessed Mr Wood, administered oxygen and attached a defibrillator while staff continued chest compressions.

127. Four minutes after the code blue, an officer called an ambulance. At 7.57pm, paramedics arrived and took over Mr Wood's care. They noted that his blood pressure rose to normal levels. At 8.40pm, they took Mr Wood to hospital, where he was in a coma and placed on life support. No restraints were used.

128. The nurse told the investigator that during the emergency response, she could hear prisoners shouting derogatory names to Mr Wood and making offensive remarks.

129. At 8.45pm, a governor telephoned Mr Wood's stepmother (who Mr Wood had listed as his next of kin), told her that Mr Wood had hanged himself and arranged to meet her at the hospital. At 9.15pm, a SO was appointed as family liaison officer (FLO). At 11.30pm, the FLO and the governor met Mr Wood's stepmother and father at the hospital.

130. On 9 September, hospital staff withdrew Mr Wood's life support, and, at 1.11pm, a hospital doctor pronounced that Mr Wood had died. His next of kin were present.

131. After Mr Wood died, the police recovered some undated notes from his cell. The police told the investigator that initially Mr Wood was relatively positive writing about his plans for release. However, after he was charged with further offences, his tone was less positive.

132. The FLO remained in contact with Mr Wood's next of kin. In line with Prison Service policy, the prison offered a contribution to Mr Wood's funeral expenses.

Support for prisoners and staff

133. After Mr Wood's death, a CM 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.

134. The prison posted notices informing other prisoners of Mr Wood'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 Wood's death.

Post-mortem report

135. The pathologist concluded that Mr Wood died of hypoxic-ischaemic encephalopathy (brain damage due to a lack of blood circulating to the brain) caused by hanging. The pathologist found several superficial cuts on Mr Wood's arms and chin which appeared to be self-inflicted.

Findings

Assessment and management of risk

136. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

137. Mr Wood was subject to ACCT support from 29 July until he died, apart from a period of three days from 25 to 28 August. We recognise that staff and prisoners made considerable efforts to engage with Mr Wood. However, we have concerns about the management of his risk of harm and lack of responsivity and information sharing in relation to his increasing risk, particularly on 6 September and 7 September.

138. During Mr Wood's time at Exeter, he had ten ACCT case reviews which were chaired by six different SOs. A consistent case manager should have chaired these reviews. We do, however, recognise that several of these case reviews were unplanned and followed an incident of self-harm, making a consistent case manager chairing all the reviews virtually impossible. However, there was no named case coordinator on the front cover of the ACCT document.

139. Furthermore, following these incidents of self-harm or using a ligature, staff did not hold immediate ACCT reviews. Staff typically increased Mr Wood's observations but the reviews always took place the following day, regardless of the time of day the incident had taken place. PSI 64/2011 notes that an urgent case review needs to take place as soon as possible if a prisoner's risk is likely to have increased, as was the case indicated by the increased observations.

140. Mr Wood told staff that his family were supportive of him. There is no evidence that any of his family were included in the ACCT review process, or that Mr Wood's consent was sought to do this in line with PSI 64/2011. Mr Wood had significant telephone contact with his family, and this was a missed opportunity to include them in Mr Wood's care.

141. Mr Wood was sentenced to a further period of imprisonment on 13 August. This was noted as a trigger on his ACCT document. He did not attend court as he was self-isolating. However, despite asking, Mr Wood did not find out what had happened at court for several days. This was unacceptable and contrary to local policy which indicates that prisoners must have a risk assessment when their status changes – in this case Mr Wood had changed from being a remand to a sentenced prisoner.

142. It is also concerning that the ACCT review scheduled for 7 September did not take place. A SO had been scheduled to do the review and was working on C wing that day. The SO had started preparing for this by reading Mr Wood's documentation and speaking to staff. However, he was then called to an incident at height as he

was the only trained negotiator in the prison at the time. The SO told the investigator that he was about to do the review when he heard the emergency code in relation to Mr Wood on the radio.

143. The clinical reviewer noted that Mr Wood's risk increased during the time he was at Exeter. There were twelve incidents of self-harm and suicidal behaviour and these increased in frequency and severity in September 2021. We are particularly concerned about missed opportunities to adequately assess Mr Wood's risk and share relevant information on 6 September and 7 September. These are discussed further below.

Events of 6 September

144. Mr Wood tied a ligature around his neck on the evening of 6 September. There are conflicting accounts about what happened following this. Nurse A said that Mr Wood asked to go on constant observation, but a CM said this was not necessary. She said that, as she was fairly new to the prison, she did not feel able to challenge a CM's assessment of risk at the time. The CM denied that Mr Wood asked to go on constant supervision. We are unable to determine whether this conversation took place. However, the CM said that a SO informed him that he had increased Mr Wood's observations to hourly and he was satisfied that that was appropriate at the time.

145. Nurse A also told the investigator that she saw a frayed ligature which she assumed had snapped when Mr Wood applied pressure to it, whereas an officer recorded that they had cut the ligature from Mr Wood and his feet had remained on the floor. If the latter is correct, communication between staff in such a critical and risk related situation was inadequate.

146. Neither Nurse A nor Nurse B recorded the incident on Mr Wood's medical record or wrote in his ACCT document. Both nurses recognised that this was unacceptable. Since Mr Wood's death, the temporary Head of Healthcare has reminded staff of the importance of accurately recording interactions with prisoners and often spoke about it in handover sessions. The clinical reviewer noted that she had been assured by both nurses that they recognised the seriousness of their omission and had reflected and learnt from this. We concur with this opinion.

147. None of the staff we spoke to said that they asked Mr Wood about what his intentions had been in tying the ligature, whether he wanted to kill himself and whether he would attempt to do so again. The clinical reviewer noted that research shows that asking a person who presents with suicidal thoughts direct questions about their intent, decreases the likelihood of a person acting on these thoughts. Aside from this, these questions were necessary to make an informed risk assessment of Mr Wood at that time.

Events of 7 September

148. A nurse said that when she assessed Mr Wood on 7 September, she was not told that he had just tied a ligature but assessed his chest pains. The officer said that they did inform the nurse. It has not been possible to determine if this was the case. She said if she had known that Mr Wood had just tied a ligature, when she saw him on 7 September, she would have discussed him with the team. She did

not see the ACCT document that day. The temporary Head of Healthcare said that the nurse should have at least been aware of the ligature tied the night before from the handover sheet.

149. A SO also said that he did not know about the ligature when he went to Mr Wood's cell. He said that if he had been told about the ligature, he would have considered whether Mr Wood's ACCT observations needed to be increased or he needed to have an immediate review. He said he would also have informed Oscar 1, who was in charge of the prison at the time.

150. There is no evidence that the three officers who removed the ligature from Mr Wood considered holding an ACCT review or increasing Mr Wood's observations. At least two of these members of staff were also aware that he had tied a ligature the night before. The increase in seriousness and frequency of Mr Wood's behaviour should have led staff to hold an immediate ACCT case review.

151. A nurse also assessed Mr Wood on 7 September. She said that she was unaware of the ligatures he had tied that day and the day before. She said that she would usually write in a prisoner's ACCT but had omitted to do so on 7 September. Had she looked at the ACCT, she would have at least been aware of the ligature Mr Wood had tied that morning.

152. Overall, we are very concerned by the often-ineffective communication between staff, whether written or verbal, such that crucial risk information about Mr Wood was not shared effectively and therefore an informed risk assessment could not be made. Mr Wood's risk to himself was clearly increasing in the days before he died. He was subject to hourly observations which were not enough to manage his increasingly risky behaviour. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **a named consistent case manager chairs ACCT reviews;**
- **staff hold an urgent case review when a prisoner's risk increases;**
- **a prisoner's family and friends are included in the ACCT process where appropriate;**
- **staff hold ACCT reviews as scheduled;**
- **staff appropriately question prisoners following an incident of self-harm or attempted suicide; and**
- **staff record and share all information that affects risk.**

153. Additionally, within the two hours before he was found hanging in the evening of 7 September, Mr Wood pressed his cell bell twice, complaining of chest pains and asking to see healthcare staff. Prison staff did not ask healthcare staff to see him. Given Mr Wood had already collapsed once that day and been found with a ligature, staff should have prioritised this. We make the following recommendation:

The Governor should ensure that prison staff inform healthcare staff when a prisoner asks to see them.

Training

154. All healthcare staff we interviewed said they had not received the full two-day ACCT training, some said they had recently had an hour's training on the new version of ACCT. The temporary Head of Healthcare said that she was pursuing ACCT training for all healthcare staff.

155. Officer B was on a shadowing week at the prison and was still doing her initial officer training when she found Mr Wood with a ligature. She said that she was fairly new to the ACCT process and was not completely sure how to handle the situation when she found Mr Wood with a ligature. We are concerned that neither she, nor those who should have been supporting her had been adequately trained to appropriately assess the risks involved.

The Governor and Head of Healthcare should ensure that all staff have received full (two day) ACCT training and that they are satisfied that staff can appropriately assess a prisoner's risk to themselves.

Risk from others

156. Mr Wood repeatedly stated that he was at risk from others and that this risk followed him when he moved wings. The investigator did not find any evidence of any threats or abuse being directed specifically towards Mr Wood. Nor did Mr Wood name any prisoners who were targeting him. However, staff noted in July and August that they intended to open a CSIP for Mr Wood. This never happened. This could have run alongside the support he was receiving through the ACCT process and allowed staff to assess the risk of a threat from other prisoners more formally and support Mr Wood. Furthermore, since Mr Wood self-isolated due to stating he had Covid-19 symptoms on three separate occasions (he never tested positive), according to local policy this meant that he should have automatically been referred for a CSIP.

157. While staff did not hear any comments directed specifically at Mr Wood, it is clear that when the prisoners who had been located on B wing, moved to A4 landing, they were subject to abuse and derogatory remarks from other prisoners on the wing. This is documented in the wing observation book and was reported to us by staff and prisoners. Some of this abuse allegedly encouraged prisoners on A4 to kill themselves. Mr Wood moved to A4 on 4 September and after this time his risk to himself and ligature attempts increased significantly. He repeatedly said he felt unsafe, and, at the time, there was no gate separating A4 from the other landings, but an officer prevented access to the landing. (This was rectified soon after Mr Wood's death.)

158. The Head of Safety acknowledged that at the time CSIP had not been working well but that this had since been relaunched. He said that they had a lot of inexperienced staff at Exeter who they were training and that staffing levels had also improved since Mr Wood's death. Both the IMB and HMIP have noted their concerns about prisoners feeling unsafe and how well CSIP was operating at the prison. It is also an issue we have identified following recent deaths at the prison. We therefore make the following repeated recommendation:

The Governor should ensure that incidents of violence, bullying or intimidation are investigated and dealt with in line with local and national policies.

Clinical care

159. The clinical reviewer concluded that the clinical care Mr Wood received at Exeter was not of a reasonable standard and not equivalent to that he could have received in the community.

160. The clinical reviewer noted that at the time Mr Wood was at Exeter, there was a significant shortage of healthcare staff, with staff working extended hours to cover the service. Staff reflected that it was an extremely challenging time and they often had to take on multiple healthcare roles during the day which was not sustainable. The Head of Healthcare was also on long-term sick leave and leadership was limited. At the time of interview, a temporary Head of Healthcare had been appointed to fill the post. She said that said that since Mr Wood's death all healthcare vacancies had been temporarily filled with agency staff.

161. The clinical reviewer concluded that there was a lack of a single case manager taking responsibility to coordinate and review Mr Wood's care. He was not on a mental health caseload as he had been referred to psychology and this was assessed as being his primary need. However, the clinical reviewer concluded that, given Mr Wood's risk to himself and mental health needs, an interim care plan should have been provided by the mental health team while he was waiting for psychological support.

The Head of Healthcare should ensure that those who are on a waiting list for therapy have access to mental health support in the interim if there is a risk of suicide and self-harm.

162. The clinical reviewer also noted that Mr Wood should have been referred to the multi-disciplinary complex case clinic (MPCCC) to be reviewed and discussed. He would have had a case manager who was responsible for coordinating his care which would have been particularly helpful as he did not have one from the primary care mental health team. This issue was identified during an initial internal investigation, the local operating policy reviewed and shared with all healthcare staff. Therefore, we do not make a further recommendation here.

163. The clinical reviewer noted that Mr Wood did not receive his antidepressant medication for the first two weeks he returned to Exeter. This was because he did not transfer with any medication, the GP who prescribed it did not review his in-possession medication status and the pharmacy did not realise he had not collected his prescription. Following Mr Wood's death, PPG identified this issue and amended their policy so that prescribers review a prisoner's medication possession assessment when prescribing and tell them when to collect it. We do not make a further recommendation here.

164. The clinical reviewer noted that prisoners starting antidepressants should be closely monitored and reviewed every two weeks. Mr Wood was reviewed a month after starting his prescription of sertraline, but this seemed to be in response to his presentation at the time rather than a planned review of his response to

antidepressant medication. The Head of Healthcare will want to note the clinical reviewer's recommendation in this regard.

165. After Mr Wood had allegedly swallowed vape solution, the plan was for clinical staff to observe him overnight and the following day. Mr Wood had regular observations overnight but there is no evidence that these took place the next day. Additionally, after the nurse assessed Mr Wood for chest pains in the morning of 7 September, she did not take any clinical observations which would have been appropriate given his cardiology history. She also sent an email directly to a mental health nurse. It was identified in an internal investigation that this should be avoided, and electronic tasks should be sent to a team and where an urgent response is needed the team should be telephoned. Furthermore, a nurse the previous night who had responded to Mr Wood making a ligature had tried to contact the mental health team but had failed to do so. She should have completed a written referral to the team.

The Head of Healthcare should ensure that:

- **when a prisoner needs clinical observations, these are completed; and**
- **staff refer prisoners appropriately to the mental health team.**

166. The clinical reviewer noted that Mr Wood had been diagnosed with a learning disability in the community. On 8 December 2020, a nurse assessed this and concluded that he did not have an obvious learning disability, but he was somewhat naïve and may have been prone to bullying or exploitation. The clinical reviewer noted that the assessment did not explore how Mr Wood processed information, solved problems, socially interacted or what support he needed to access healthcare. There is also no evidence that his vulnerability was further considered. Mr Wood did sometimes mention his learning disability to healthcare staff, but this was not sufficiently explored. The clinical reviewer notes that he should have had a long-term care plan in relation to his learning disability which would have enabled more support for his anxiety and vulnerability and increased staff awareness.

The Head of Healthcare should ensure that all prisoners with learning disabilities are clearly recorded, staff receive relevant learning disability training and follow NHSE/I guidance for prisoners with learning disabilities.

Transfer to Channings Wood

167. Mr Wood had transferred to Exeter from Channings Wood as he had pleaded guilty to further charges and was on remand. Although he had been a category C prisoner prior to this further remand, he needed to be reassessed following these further charges. The Offender Management in Custody (OMiC) policy states that initial categorisation and a move to an appropriate prison should take place within ten working days of sentencing. Mr Wood was categorised as a category C prisoner on 31 August, 11 working days after he had been sentenced. This was late as his offender manager had been on annual leave. The HMPPS Early Learning Review also noted that Exeter had a waiting list for Channings Wood and that it was not always possible to transfer prisoners within the ten-day timescale due to the lack of spaces which are allocated by HMPPS' population management department.

168. The first allocation of places at Channings Wood Exeter was given after Mr Wood had been categorised was on 9 September and the probation officer ensured that he was prioritised for transfer on that date.

169. The investigator spoke to a manager about Mr Wood's transfer to Channings Wood. The manager said that Mr Wood had been due to transfer but then said he had Covid-19 symptoms so had been self-isolating when it was due to occur and could not transfer. He denied that the recategorisation of Mr Wood being a day late had delayed his transfer.

170. A SO told the investigator that he had spoken to Mr Wood's stepmother and said that while he was on leave Mr Wood would be sentenced and then they would try and get him transferred as soon as possible after that. He acknowledged that there were several factors which could affect how quickly a prisoner could transfer and said he never told Mr Wood's family a specific date when he would transfer.

171. We recognise that whatever the reasons that Mr Wood had not transferred before he died, Exeter was making significant efforts to get him transferred to Channings Wood and had prioritised this move for 9 September.

Meaningful contact

172. The HMPPS Early Learning Review noted that Covid-19 restrictions at the time that Mr Wood was at Exeter meant that vulnerable prisoners should have had a daily wellbeing check which was noted in their record. Out of the 38 days that Mr Wood should have been checked, there were two keyworking sessions and 13 wellbeing entries in his record meaning there were 23 days where there is no evidence that these checks were completed.

173. The Head of Safety told the investigator that he had been trying to improve completion of these wellbeing checks. He also acknowledged that it had been difficult to continue with key working sessions through the pandemic and staff shortages. At the time of writing, Covid-19 restrictions were lessening, and we therefore make the following recommendation:

The Governor should ensure that the key worker scheme is properly embedded and that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role.

Emergency response

174. When staff found Mr Wood hanging, they acted quickly and competently. An officer radioed a code blue and an officer documented that he telephoned an ambulance four minutes later. A code blue emergency indicates that the control room should telephone an ambulance immediately.

175. The officer said that he did telephone the ambulance immediately, but he was on hold to the 999 operator for a couple of minutes before he got through. During this time on hold, he said that he obtained some information from staff dealing with the emergency and there was some confusion regarding the cell location of Mr Wood. In these circumstances, we accept that there was no delay in requesting an ambulance but note that records should reflect timings accurately.

Sharing Learning

176. Finally, given the learning outlined in this report, we make the following recommendation:

The Governor and Head of Healthcare should ensure that this report is shared with all staff named in it and that they are given the opportunity to reflect on the learning involved.

Inquest

177. The inquest into Mr Wood's death concluded in February 2025. It found that Mr Wood died as a result of suicide.

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