Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Lawson, a prisoner at HMP Channings Wood, on 16 February 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

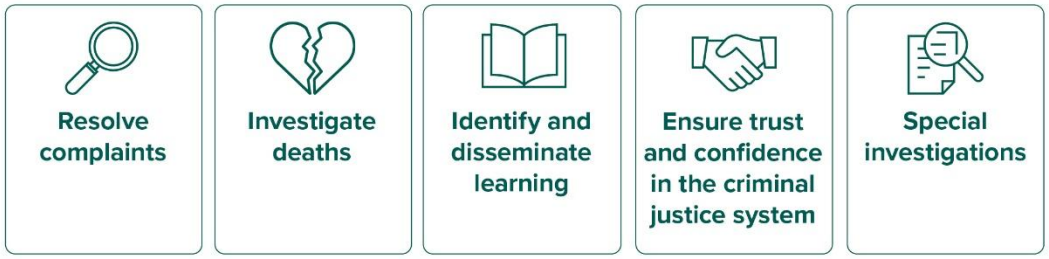
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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.

If my office is to best assist 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.

Mr James Lawson died from combined effects of compression of the neck by a ligature and incised wound to the neck on 16 February 2023 at HMP Channings Wood. He was 34 years old. I offer my condolences to Mr Lawson's family and friends.

Mr Lawson had a history of poor mental health, self-harm, and illicit drug use. He was at Channings Wood for six days before he died. While there were indications that Mr Lawson's mental health was unstable and some missed opportunities for the mental health team to have assessed and supported him, there were no clear indications that his risk of suicide had significantly increased.

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

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

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Summary

Events

1. On 3 February 2023, Mr James Lawson was recalled to prison after committing further offences while on conditional licence. He arrived at HMP Exeter on 4 February.

2. Mr Lawson had several mental health disorders, poor mental health and a history of self-harm. His mental health had deteriorated in the community, and prior to his recall to prison, he had been displaying paranoid and delusional thoughts. He had not been taking any medication.

3. When he arrived at Exeter, Mr Lawson was still struggling with his mental health. He told a nurse that he had drug-induced psychosis and that he did not have any thoughts of suicide or self-harm. Mr Lawson tested positive for opioids and the nurse referred him to the primary care mental health team (PCMHT) and the substance misuse team at the prison.

4. On 5 February, PCMHT and the substance misuse team assessed Mr Lawson. At a multi-disciplinary healthcare team meeting the next day, it was decided that there were no identified mental health reasons to refer Mr Lawson to the mental health team at that time.

5. That day, Offender Management Unit (OMU) staff received Mr Lawson's recall paperwork, which indicated that Mr Lawson's mental health had been deteriorating during appointments with his community probation officer in the community, as he appeared delusional and paranoid.

6. On 10 February, Mr Lawson was due to transfer to HMP Channings Wood, but he barricaded himself in his cell. Staff persuaded him to come out and he was transferred to Channings Wood that day.

7. On his arrival at Channings Wood, healthcare staff completed a reception health screen. A nurse noted Mr Lawson's history of illicit drug use, poor mental health and an injury to his finger. Mr Lawson did not raise any concerns and said that he had no thoughts or intentions to self-harm. The nurse wrongly recorded that Mr Lawson did not have a previous history of self-harm.

8. At 7.00pm on 16 February, an officer was conducting routine checks. She looked through the observation panel of Mr Lawson's cell, but she could not see him. She then looked around the cell and saw Mr Lawson lying on the floor. The officer was not sure if Mr Lawson was unconscious, but there was water with blood in it on the cell floor. She alerted another officer, and he radioed a medical emergency code. Control room staff called an emergency ambulance immediately.

9. Mr Lawson had blocked his cell door, and the staff accessed the cell using an anti-barricade key. On entering the cell, the staff saw a snapped ligature and a blade from a razor in the shower tray. Mr Lawson had cuts on both sides of his neck and at the back of his head. Staff placed Mr Lawson in the recovery position and used towels to stem the bleeding.

10. At 7.33pm, the paramedics arrived at the prison. While the paramedics were trying to stabilise him, Mr Lawson became unresponsive and went into cardiac arrest. At 8.21pm, a doctor confirmed that Mr Lawson had died.

Findings

11. Mr Lawson had deteriorating mental health, a history of self-harm and drug use. Healthcare staff did not refer Mr Lawson to the mental health team or substance misuse team as they should have done. Mr Lawson was at Channings Wood for six days before he died. In that time, staff had some reason to be concerned about his mental health but there were no clear signs that his risk of suicide had significantly increased.

12. In the days leading to his death, staff had some concerns about Mr Lawson's mental health, but there were no clear indications that his risk to himself, and particularly that his risk of suicide had significantly increased. We do not think that staff had reason to begin ACCT procedures.

13. The clinical reviewer concluded that the clinical care Mr Lawson received at Channings Wood was partially equivalent to what he could have expected in the community.

Recommendations

- The Head of Healthcare at HMP Channings Wood should ensure that healthcare staff completing first and second reception screen assessments use the free text section to provide more details about disclosure around a person's mental health, and where appropriate, record a defensible decision about opening an ACCT.

- The Head of Healthcare at HMP Channings Wood should ensure that all mental health and substance misuse staff are competent and confident in developing risk formulations and consider the formulation of risk at every consultation with the patient, in line with NICE 'self-harm: assessment, management and preventing recurrence' (2022).

- The Head of Healthcare at HMP Exeter should ensure that there is an automatic handover process in place so essential information about the patient is handed over to the receiving establishment and should include when controlled medication is prescribed.

The Investigation Process

14. HMPPS informed us of Mr Lawson's death on 16 February 2023.

15. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator visited Channings Wood on 23 February 2023, obtained copies of relevant extracts from Mr Lawson's prison and medical records, and viewed CCTV and Body Worn Video Camera (BWVC) footage.

17. The investigator interviewed three members of staff at Channings Wood on 3 May 2023.

18. NHS England commissioned a clinical reviewer to review Mr Lawson's clinical care at the prison.

19. We informed HM Coroner for Plymouth, Torbay, and South Devon of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. The Ombudsman's family liaison officer contacted Mr Lawson's mother to explain the investigation and to ask if she had any matters, she wanted us to consider. Mr Lawson's mother asked:

    - had her son been prescribed appropriate medication?
    - was her son on suicide and self-harm monitoring at the time of his death?
    - when was her son last seen alive?

    We have answered these questions in the clinical review report and our report.

21. HMPPS responded to the initial report and accepted all recommendations made.

22. Mr Lawson's family did not respond to the findings in the initial report.

23. An inquest was concluded on 19 May 2026 and a jury concluded that Mr Lawson's death was the result of suicide.

Background Information

HMP Channings Wood

24. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. Oxleas provides healthcare services. There is nursing cover from 7.30am to 6.00pm on weekdays and from 8.30am to 5.30pm at weekends. Devon Doctors provides an out-of-hours GP service.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Channings Wood was in July 2022. Inspectors reported that the healthcare team operated independently to prison staff, and a closer working rapport would enhance prisoner care. The healthcare team faced recruitment challenges, which had an impact on existing staff. The department relied heavily on additional hours and agency staff.

26. Inspectors reported that arrangements for providing a rapid and skilled response to medical emergencies, overseen by the prison paramedic, were comprehensive. Staff were trained to use immediate life support skills and resuscitation equipment was appropriate and regularly checked. Prison staff provided the first response once the healthcare team had left the site, and most staff had received first aid training and could access automated external defibrillators (AEDs) on the wings. The report also said that a new project 'Threads,' aimed to reduce self-harm, violence and suicide in prison had begun. While this was a promising initiative, it was too soon to see if it had made an impact.

Independent Monitoring Board

27. 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 August 2022, the IMB reported that the number of prisoners harming themselves during the year showed a drop of 17% over the number recorded in the previous year.

Previous deaths at HMP Channings Wood

28. Mr Lawson was the ninth prisoner to die at HMP Channings Wood since 2020. Of the previous deaths, seven were natural causes and one was self-inflicted. There are no significant similarities between our findings in the investigation into Mr Lawson's death and the other deaths.

Assessment, Care in Custody and Teamwork

29. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular

multidisciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care plan to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

30. On 26 November 2021, Mr Lawson was sentenced to eighteen months in prison for affray. On 13 April 2022, he was released from HMP Channings Wood and was subject to licence conditions and Home Detention Curfew. (HDC is a scheme that allows certain prisoners to serve the last part of their sentence at home, or another suitable address, for up to a maximum period of six months.)

31. Mr Lawson had several mental health disorders including panic disorder, drug-induced psychosis, bipolar affective disorder, post-traumatic stress disorder (PTSD), recurrent depressive disorder, generalised anxiety disorder, attention deficit hyperactivity disorder (ADHD) and emotionally unstable personality disorder. He also had a history of drug and alcohol use and a history of self-harm by overdose.

32. On 3 February, Mr Lawson was arrested for actual bodily harm and common assault, and he was recalled to prison. The next day, Mr Lawson appeared at court and was remanded to HMP Exeter. The Person Escort Record (PER) that accompanied Mr Lawson highlighted a suicide and self-harm warning and indicated that he had a history of self-harm. It also noted that Mr Lawson had said that if he was transferred to Exeter he would 'get killed there' and if he did not get killed at Exeter, he would kill himself.

33. On his arrival at Exeter, staff conducted a reception screen and recorded that Mr Lawson had a history of self-harm, but that he denied any current thoughts of suicide and self-harm. Staff did not begin suicide and self-harm prevention procedures (ACCT).

34. Nursing staff completed an initial health screen and noted Mr Lawson's history of self-harm. Mr Lawson engaged well during the reception process, although the nurse noted that Mr Lawson appeared paranoid, delusional and chaotic in his presentation. Mr Lawson told the nurse that he was emotionally upset but that he had no thoughts of suicide or self-harm. He also said that he had suffered with drug-induced psychosis for some time and had been prescribed buprenorphine (a substitution treatment for opioid dependence) in the community. Mr Lawson tested positive for buprenorphine and cannabis. The nurse referred him to the primary care mental health team (PCMHT) and the drug and alcohol recovery team (DART).

35. That day, a GP at the prison saw Mr Lawson. Mr Lawson said that he had got into a fight two days before he had been recalled to prison. He said that the top of his finger had been bitten and he had attended hospital for treatment. The GP prescribed Mr Lawson some more antibiotics and pain relief.

36. On 5 February, PCMHT and DART completed assessments of Mr Lawson's needs. The PCMHT noted that there was no evidence of psychosis, Mr Lawson was no longer taking any mental health medication and so concluded that there were no mental health reasons to refer him to the mental health team at that time. The DART assessment indicated mild withdrawal symptoms and the next day Mr Lawson restarted buprenorphine medication to help manage his symptoms.

37. On 6 February, community probation staff shared Mr Lawson's recall paperwork with Offender Management Unit (OMU) staff at Exeter, which indicated that there

had been a deterioration in Mr Lawson's mental health leading up to his recall. It said that Mr Lawson had appeared delusional and paranoid during the appointments with his supervising probation officer. OMU staff did not share this information with the mental health team at Exeter.

38. On 8 February, Mr Lawson was placed on the basic level of the Incentives and Earned Privileges (IEP) scheme (meaning he had reduced access to some in cell items and other privileges), after he was found with a handmade weapon. He had also been found throwing pieces of burning toilet paper from his cell window.

39. On 9 February, Mr Lawson was involved in an altercation with another prisoner. Following the incident, a nurse from the PCMHT spoke to Mr Lawson. She recorded that Mr Lawson was the victim and had not started the fight. She noted that Mr Lawson was very chatty and talked at length about his past violence and that he thought he was 'being set up'. She noted that during this conversation, Mr Lawson showed signs of humour, and when the nurse interrupted him, Mr Lawson became very grounded and sensible, but would return to his narrative about his past violence. She noted that this behaviour did not present as psychosis.

40. However, the nurse noted that during the conversation, Mr Lawson was displaying symptoms of hyperactivity and he was unable to say when he had last received medication for this. She noted that Mr Lawson had been using alcohol and substances in the community, but he had not been taking any prescription medication, and that he might benefit from a review of his ADHD. There is no evidence that this was taken forward.

41. On 10 February, Mr Lawson was due to transfer to Channings Wood, but he barricaded himself in his cell. Staff persuaded Mr Lawson to remove the barricade, which he did, and he was transferred to Channings Wood that day. Mr Lawson did not say why he did not want to transfer to Channings Wood.

HMP Channings Wood

42. On his arrival at Channings Wood, staff conducted a reception screen. Mr Lawson said that he had no concerns with being at Channings Wood and had no thoughts or intentions of suicide or self-harm. Nursing staff completed a reception health screen and recorded Mr Lawson's history of illicit drug use, poor mental health, and an injury to his finger. The nurse noted that Mr Lawson appeared anxious and that he made poor eye contact. Mr Lawson again said that he had no thoughts of suicide or self-harm. The nurse incorrectly recorded that Mr Lawson had not previously self-harmed and did not refer Mr Lawson to the mental health team or the substance misuse team.

43. Mr Lawson was located on the induction wing and during the first night, staff observed Mr Lawson regularly and he did not raise any concerns.

44. On 11 February, an officer completed an induction with Mr Lawson. She was aware that Mr Lawson had been placed on the basic IEP level when he arrived at Channings Wood to reflect his IEP level at Exeter. She spoke to senior staff about moving Mr Lawson back on to the standard level as a fresh start, which was agreed. She had no concerns about Mr Lawson during her initial contact.

45. The next day, a member of the substance misuse team at Channings Wood spoke to Mr Lawson. She recorded that Mr Lawson presented and engaged well; he was polite throughout the assessment but gave short answers. Mr Lawson said that he had not wanted to transfer to Channings Wood, but he did not want to say why. He told her that he suffered with depression and felt unsettled. She recorded that Mr Lawson had been prescribed buprenorphine, but he said that he did not feel stable on the current dose. She reassured him that she would arrange for healthcare staff to review this (Mr Lawson died before this had been arranged).

46. The substance misuse worker recorded that Mr Lawson appeared quite paranoid and spoke about the police 'fitting him up' and that people were out to get him, but when she asked Mr Lawson to expand on these beliefs, he could not explain why he felt that way. Mr Lawson said that he had self-harmed in the past and that he had stabbed himself in the stomach and face. Mr Lawson told her that he had no current thoughts or intent of suicide or self-harm. She signposted Mr Lawson to other support services in the event he needed additional support.

47. On 14 February, a nurse saw Mr Lawson to change the dressing on his finger. During the appointment she discovered that the tip of his finger had become necrotic (dead cells) due to a lack of blood flow. Arrangements were made for Mr Lawson to attend the local hospital the following day for treatment.

48. At approximately 8.30am the next day, 15 February, staff went to collect Mr Lawson from his cell for his hospital appointment. The cell door was barricaded. A Supervising Officer (SO) attended the cell after being told what had happened. She spoke to Mr Lawson through his door and asked him why he had made the barricade. Mr Lawson said that he was unsure who was on the landing and that people thought he was a sex offender. She said that she tried to get more information from Mr Lawson, but he did not expand and did not give names of anyone who had been saying things to him. Mr Lawson said that he knew that people thought it and said that the police had set him up. She reassured Mr Lawson that the officers had just come to collect him for his hospital appointment so he could have his finger looked at. Mr Lawson replied, 'oh, yeah that is fine. I will go with them' and asked who else was outside the cell. She reassured him that it was just her and the two officers.

49. After around twenty minutes, Mr Lawson removed the barricade. The SO entered the cell and had a further conversation with Mr Lawson. She asked him why he had made the barricade and why he thought people thought he was a sex offender. Mr Lawson, at this point, was more concerned about going to hospital and getting his medication before he left. She walked with Mr Lawson to collect his medication and asked him about his mood. Mr Lawson said that he was fine and said, 'I just have a funny five minutes like this sometimes and I just got a bit paranoid. I did not want people coming in my cell overnight'. She said that when she asked Mr Lawson who he thought was coming to his cell, he was again unable to give an answer. Mr Lawson said, 'I do not know, just in case.' Mr Lawson also told her that he was fine and that he was not going to do anything to himself or anyone else. She said that Mr Lawson appeared quite upbeat at this stage.

50. Mr Lawson spoke to the SO about how he got the injury on his finger and told her that he was paranoid and did not really trust anyone. She asked him whether he had seen anyone from the mental health team and Mr Lawson said that he had.

She told Mr Lawson that she would complete a referral so he could speak to mental health staff again. She left Mr Lawson in reception and returned to the wing. She had no concerns about his risk of suicide or self-harm and did not consider that he needed support under ACCT procedures.

51. Ten minutes after taking Mr Lawson to reception, the SO received a telephone call from a Custodial Manager (CM). He told her that reception staff had found a handmade weapon made from a sharpened handle of a piece of cutlery on Mr Lawson and that he had told them that he had carried it to protect himself. The CM asked her to complete paperwork for Mr Lawson to be immediately downgraded to the basic IEP level. She completed this and started the referral paperwork to the mental health team but did not complete it because Mr Lawson had not returned from hospital before she finished her shift. She said she had waited for Mr Lawson to return because she wanted to involve him in the referral so that his concerns were reflected correctly. She had no further contact with Mr Lawson.

52. Mr Lawson attended hospital as planned. Hospital staff informed him that his finger needed to be partially amputated and that an appointment had been arranged for 23 February. On his return to prison, staff recorded no concerns about him.

Events on 16 February

53. At around 8.25am on 16 February, Mr Lawson refused to leave his cell to collect his medication from the medication hatch. An officer went to collect Mr Lawson at 10.54am to take him to see healthcare staff for his post-hospital checks. The officer recorded that Mr Lawson refused to go and said that he was suffering with his mental health. The officer incorrectly told Mr Lawson that a mental health referral had been made.

54. Officer A started her shift at lunchtime. She went to unlock Mr Lawson's cell and found that Mr Lawson had created a barricade. She spoke to Mr Lawson and told him to take down the barricade and asked him why he had done this. Mr Lawson told her that he was concerned about other prisoners coming into his cell. She said that she was aware that Mr Lawson was keeping to himself and had not been coming out of his cell other than for his medication. She reassured Mr Lawson that no one other than staff was going to come into his cell, and that he needed to take the barricade down so that staff could get in and see to him if they needed to. She told the investigator that the barricade was not up against the door at this time and consisted of furniture being placed in a way that created a barrier between Mr Lawson and the door, but she was still able to access the cell. She said that she had no concerns about Mr Lawson's risk at that time.

55. At around 4.00pm, staff took Mr Lawson's evening meal to his cell. Mr Lawson did not raise any concerns and staff were not concerned about him.

56. At approximately 7.00pm, Officer A started the evening routine checks. When she arrived at Mr Lawson's cell at around 7.08pm, she looked through the observation panel and could not see him. She looked around the cell and saw Mr Lawson lying on the floor. She was not sure if he was unconscious, but his eyes were closed. There was blood in water on the cell floor and a barricade against the door. She alerted her colleague, a SO, who radioed a code red emergency (indicating a

prisoner is bleeding). Control room staff called an emergency ambulance immediately.

57. The SO and officer A tried to kick the door open to enter Mr Lawson's cell. Due to the furniture being placed behind the door and wedged against the bed, they were unable to gain entry. The officer could see Mr Lawson moving. She then ran to the wing office to collect an anti-barricade key. (Prison cell doors are fitted with an anti-barricade bar, which can be removed using a tool that allows the door to open outwards.)

58. Officer A returned with the key and staff removed the bar and opened the cell door. HMP Channings Wood does not have 24-hour healthcare cover and at 7.00pm, no nursing staff were present at the prison.

59. Other staff attended the cell and an officer turned on her body worn video camera (BWVC), which remained switched on throughout the emergency response.

60. Mr Lawson was lying on the floor, and he was unconscious. Staff said that they saw what they believed to be a snapped ligature in the shower tray made from a bedsheet or a pillowcase, and a blade from a razor. It was not possible to confirm whether Mr Lawson had used the torn sheet as a ligature or a torniquet to increase the bleeding. On assessing Mr Lawson, they found he had a deep cut on the left-hand side of his neck and a cut on the back of his head, which was also bleeding. Mr Lawson became responsive, and staff talked to him, reassured him that paramedics were on their way and that he was going to be all right.

61. Staff placed Mr Lawson in the recovery position and used towels to stem the bleeding from the wound on his neck and back of his head. Staff updated the ambulance on the nature of Mr Lawson's injuries. Mr Lawson began to move and told staff he was trying to get comfortable, and as he did, staff found another deep cut on the right side of his neck. Staff applied more pressure to stem the bleeding. Staff said that the wound on the left side appeared to stop bleeding and was not as significant as the one the right side.

62. At 7.33pm, the first paramedic crew arrived at the prison. They assessed Mr Lawson and attempted to get a pulse and oxygen reading. Suddenly, Mr Lawson became unresponsive and gasped for breath. He then went into cardiac arrest. Paramedics continued with CPR and a further team of critical care paramedics, including a doctor arrived. Mr Lawson remained unresponsive, and the doctor advised that treatment should stop. At 8.21pm, the doctor confirmed that Mr Lawson had died.

Contact with Mr Lawson's family

63. The prison appointed a family liaison officer (FLO). The FLO and a prison governor attended Mr Lawson's mother's home that evening and informed her of her son's death. The FLO and the governor answered the initial questions raised by the family and provided information on the process that would follow.

64. The FLO telephoned Mr Lawson's mother the following day to check on her well-being and provide her with details for the coroner. During the call, Mr Lawson's mother asked further questions around the circumstances that had led to her son's

recall to prison and said that he had been struggling with his mental health. Mr Lawson's mother said that she had informed his probation officer of her concerns and a meeting had been arranged but Mr Lawson failed to attend. Mr Lawson's mother also told the FLO that her son believed people were going to harm him and when he lived with her, he would often carry weapons and barricade his bedroom out of fear.

65. The FLO remained in close contact with Mr Lawson's family and arranged for the family to visit the prison.

66. The prison contributed towards the cost of the funeral in line with national policy.

Support for prisoners and staff

67. After Mr Lawson'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.

68. The prison posted notices informing other prisoners of Mr Lawson'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 the death.

Post-mortem report

69. The post-mortem report gave Mr Lawson's cause of death as combined effects of compression of the neck by a ligature and incised wound to the neck. The pathologist said that it was not possible to determine from the medical evidence in isolation at what point the ligature was applied to the neck and the cuts were made. Toxicology results found no illicit substances in Mr Lawson's body.

Findings

Assessment of Mr Lawson's risk

70. Mr Lawson had been at Channings Wood for six days when he killed himself. He had some risk factors for suicide and self-harm including having recently been recalled to prison, a history of mental health disorders and self-harm. We have considered whether staff should have identified Mr Lawson as at imminent risk of suicide in the days leading to his death or should have begun ACCT procedures to support him.

71. There were indications that Mr Lawson was experiencing poor mental health, including him showing signs of paranoia, barricading himself in his cell and beginning to isolate himself from others, and that staff were concerned about this. A SO began a referral to the mental health team on 15 March (which she had not completed before Mr Lawson died) and the evidence indicates that she took a thorough approach to considering Mr Lawson's mood and risk to himself. She did not consider that he needed ACCT support. On balance, we think this was a reasonable assessment.

72. On 16 March, staff were again concerned about Mr Lawson's mental health but thought that he had been referred to the mental health team. However, we do not think that his behaviour or presentation indicated that he was at imminent risk of suicide.

Clinical care

73. The clinical reviewer concluded that the clinical care Mr Lawson received at Channings Wood was partially equivalent to what he could have expected to receive in the community.

Management of Mr Lawson's mental health

74. The clinical reviewer found that when Mr Lawson arrived at Channings Wood he should have been referred to the mental health team but was not. The reception nurse noted his history of mental ill-health and described Mr Lawson as appearing anxious and he expressed his unhappiness about being transferred to Channings Wood. The clinical reviewer considered that these were potential issues relating to his emotional and psychological wellbeing. Mr Lawson also told a member of the substance misuse team (on 12 February) that he had depression and felt unsettled about being transferred to Channings Wood, and on 15 February, a SO had planned to complete a mental health referral, but it was not completed. The clinical reviewer considers that these were further missed opportunities to refer Mr Lawson to the mental health team for additional support.

75. The clinical reviewer considered that healthcare staff should have completed a formulation of risk, in line with the National Institute for Health and Care Excellence (NICE) 'self-harm: assessment, management and preventing recurrence' (2022). The formulation should have taken into account previous identified indicators including self-isolation and increasing persecutory beliefs, to determine an ongoing supportive care plan for Mr Lawson. We recommend:

The Head of Healthcare at HMP Channings Wood should ensure that healthcare staff completing first and second reception screen assessments use the free text section to provide more details about disclosure around a person's mental health, and where appropriate, record a defensible decision about opening an ACCT.

The Head of Healthcare at HMP Channings Wood should ensure that all mental health and substance misuse staff are competent and confident in developing risk formulations and consider the formulation of risk at every consultation with the patient, in line with NICE 'self-harm: assessment, management and preventing recurrence' (2022).

76. The clinical reviewer also reported the lack of handover from healthcare staff at HMP Exeter to healthcare staff Channings Wood. Healthcare staff at Exeter considered that Mr Lawson would benefit from a review of his ADHD. While this was recorded in his medical record, it was not formally handed over to the mental health team at HMP Channings Wood. The clinical reviewer considered that it would have been good practice to arrange a handover ahead of Mr Lawson's transfer, in light of Mr Lawson also being prescribed buprenorphine, so that the medication could have been checked as being available at Channings Wood. We recommend:

The Head of Healthcare at HMP Exeter should ensure that there is an automatic handover process in place so essential information about the patient is handed over to the receiving establishment and should include when controlled medication is prescribed.

77. The clinical reviewer has made other recommendations to the Heads of Healthcare at HMP Exeter and HMP Channings Wood, which they will wish to address.

Governor to note

Emergency response

78. We commend the staff involved in the emergency response for their concerted efforts to try to help Mr Lawson, offering comfort and reassurance in what were clearly difficult circumstances.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100