Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Mason, a prisoner at HMP Durham, on 8 December 2022

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.

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

Mr Mark Mason died on 8 December 2022, after he was found hanging in his cell at HMP Durham. This was the seventh self-inflicted death at Durham in three years. Mr Mason was 45 years old. I offer my condolences to his family and friends.

Mr Mason said he had lived with thoughts of self-harm for years, but had resisted because of his love for and from his family and partner. He was not subject to any additional monitoring at the time of his death.

My investigation found that there were missed opportunities to provide support to Mr Mason for his mental health and to manage the risk he posed to himself. The clinical reviewer concluded that the mental health care Mr Mason received at Durham was not equivalent to that which he could have expected to receive in the community.

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 **October 2023**

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Summary

Events

1. On 11 October 2022, Mr Mark Mason was remanded to prison, charged with burglary and assault, and sent to HMP Durham.

2. Between 31 October and 27 November, Mr Mason's partner contacted the prison four times, raising concerns about Mr Mason's safety. Mr Mason had told his partner that he thought other prisoners were going to attack him. Mr Mason had no known issues on the wing but would not come out of his cell because he said he was scared. Mr Mason told staff he did not know why he was under threat or from whom.

3. On 22 November, a supervising officer made a mental health referral for Mr Mason as staff had reported that he was 'hearing voices and was paranoid'.

4. On 29 November, Mr Mason's partner contacted the prison again saying Mr Mason needed to move wings as he was under threat. An officer conducted a welfare check and noted that Mr Mason told him he was ok, and that his partner just worried a lot. Mr Mason's cellmate told the officer that Mr Mason was paranoid.

5. On 6 December, during a mental health assessment, Mr Mason became distressed when he told the nurse that he was scared to leave his cell and wanted to be moved somewhere safer. He said that he had had thoughts of self-harm for some years but had managed not to act on them because of his family and partner. The nurse assessed that Mr Mason was not psychotic but was anxious and low in mood. She made a GP referral. She also offered to refer Mr Mason for anxiety management but he declined. She discharged Mr Mason from the mental health team. She discussed his safety fears with a wing officer who agreed to look into a wing move. She did not mention Mr Mason's thoughts of self-harm. The nurse did not think that Mr Mason needed to be monitored under suicide and self-harm prevention procedures.

6. On 7 December, Mr Mason's cellmate was released from Durham. During telephone calls to his partner, Mr Mason expressed anxiety about who his new cellmate might be and whether they might be connected to the prisoners who wanted to harm him.

7. On 8 December, at 9.30am, an officer arrived at Mr Mason's cell with his new cellmate. When he opened the cell door, they found Mr Mason had tied a ligature around his neck and attached it to the bedframe. The officer called a medical emergency code. He cut the ligature and started cardiopulmonary resuscitation (CPR). A nurse then arrived and assisted with CPR. Control room staff called an ambulance. Paramedics arrived at 9.49am and along with the nurse continued CPR. At 10.07am, paramedics pronounced that Mr Mason had died.

Findings

8. We found no evidence that supported Mr Mason's concerns that he was under threat from other prisoners. Staff did not therefore arrange a wing move, which seems reasonable in the circumstances.

9. The clinical reviewer considered that given Mr Mason's presentation during his mental health assessment and his persistent thoughts of self-harm, the mental health team should have offered further assessment and support.

10. The nurse who conducted the mental health assessment on 6 December, had not properly reviewed Mr Mason's medical records and had not identified that he had a history of suicide attempts. This information would have added to the overall picture of Mr Mason's risk to himself and was again a missed opportunity, as was the failure to pass on relevant information to wing staff. The clinical reviewer concluded that the mental health care Mr Mason received was not equivalent to that which he could have expected to receive in the community.

11. There was a delay in the emergency response, due in part to the delay in passing information to the control room.

Recommendations

- The Head of Healthcare should ensure that all members of the Mental Health Team:
    - thoroughly check medical records prior to conducting assessments, so that relevant historic information forms part of any consideration and management of a prisoner's risk of suicide and self-harm; and
    - understand the importance of communicating risk information to relevant members of prison staff.
- The Prison Group Director and Governor should examine in detail their processes for acquiring an urgent ambulance, in conjunction with their partners in the local ambulance service.

The Investigation Process

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

13. The investigator visited Durham on 2 and 3 April 2022. He obtained copies of relevant extracts from Mr Mason's prison and medical records.

14. The investigator interviewed three members of staff at Durham on 2 and 3 April 2022. The remaining five interviews took place over video call on 18 January, 9 March and 17 March 2023. The investigator tried to interview Mr Mason's cellmate but he had died shortly after his release.

15. NHS England commissioned an independent clinical reviewer to review Mr Mason's clinical care at the prison. The investigator and clinical reviewer conducted two joint interviews with healthcare staff on 18 January.

16. We informed HM Senior Coroner for County Durham and Darlington of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Mason's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She was concerned that Mr Mason was under threat from other prisoners, and asked how the prison responded to this issue. She also said that Mr Mason had activated his cell bell 15 minutes before he was found hanging. We have addressed these issues in our report.

Background Information

HMP Durham

18. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. It has an operational capacity of 985 men. Spectrum Community Health CIC provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Durham was in November 2021. Inspectors reported that serious staff shortages had affected all aspects of healthcare provision and caused delays for prisoners trying to access support. There was a high level of demand for mental health care and referrals were received from a variety of sources, including self-referral. These were triaged daily by the urgent care staff and any patients deemed to have urgent needs were assessed within four hours. Routine referrals were taking up to three weeks to assess in secondary care and up to four weeks in primary care, which was too long.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 October 2022, the IMB reported that Durham was a safe prison, with safety a priority for staff at all levels. However, prisoners were not satisfied with the expediency of healthcare available.

Previous deaths at HMP Durham

21. Mr Mason was the eighteenth prisoner at HMP Durham to die since December 2019. Of the previous deaths, six were self-inflicted, two were drug-related and nine were from natural causes. Mr Mason's death was the third self-inflicted death at Durham in 2022 and there has been one self-inflicted death since.

22. Due to the number of recent self-inflicted deaths at Durham, the prison has been receiving additional monitoring and support from HMPPS Headquarters. HMPPS has delivered training on identifying risks, triggers and protective factors when prisoners arrive at Durham and work is ongoing to improve first night procedures.

23. We have previously made a recommendation about ensuring healthcare staff review the prisoner's medical record before carrying out a mental health assessment. We were told that the mental health triage and assessment processes had been reviewed. All patients referred into the team are now offered a face to face triage within 24 hours, which includes a discussion on current and previous engagement with services. A formal process is also in place to allow both regional community mental health trusts to review each system, with information being reviewed and returned within 24 hours.

24. We have also previously made recommendations about the importance of communicating the details of a medical emergency as quickly as possible and control room staff calling an ambulance as soon as they hear a medical emergency code. In response, we were told that control room staff were aware of this requirement and that instructions were displayed in the control room.

Key Events

25. On 11 October 2022, Mr Mark Mason was remanded in prison, charged with burglary and assault. He was sent to HMP Durham. It was not his first time in custody.

26. When he arrived at Durham, Mr Mason tested positive for benzodiazepines, a type of sedative medication that he was not prescribed. A nurse completed Mr Mason's reception health screen and noted that Mr Mason had a history of alcohol abuse and benzodiazepine dependence. He prescribed medication to treat Mr Mason's drug and alcohol withdrawal and arranged for staff to monitor Mr Mason on his first night. He noted that Mr Mason needed to be seen, monitored, and supported by healthcare, and the Drug and Recovery Team (DART).

27. Another nurse completed the secondary health screen. Mr Mason told her he had not self-harmed or attempted suicide in the last 12 months, and he had no current thoughts of suicide or self-harm.

28. Prison staff completed a vulnerability assessment form for Mr Mason. They noted he had no suicide and self-harm risks and that he told them that he had not self-harmed or attempted suicide in the community or prison. (Mr Mason's medical records note that in 2018, while serving a previous sentence at Durham, Mr Mason told a nurse that he had a history of attempted suicide by hanging, use of carbon monoxide and overdose. Prison staff would not have had access to Mr Mason's medical records.)

29. On 14 October, Mr Mason was moved to a shared cell on C Wing.

30. On 21 October, Mr Mason saw a substance misuse worker as part of the non-clinical DART induction process. Mr Mason told her that he did not have issues with drugs or alcohol and declined to engage. She advised Mr Mason of the self-referral process if he changed his mind.

31. On 31 October, Mr Mason's partner contacted the prison after Mr Mason told her he was scared for his safety. An officer visited Mr Mason who said that he had overheard other prisoners on the wing threatening to 'set about' someone in his cell. The officer noted that Mr Mason had no known issues on the wing and that he told her he did not know why he would be under threat. Mr Mason told her that he would report anything further to staff and that he understood what support was available to him.

32. On 7 November, the Safer Custody Department contacted a supervising officer (SO) on Mr Mason's wing, as his partner had again raised concerns about Mr Mason's welfare. The SO noted that Mr Mason told her that he heard other prisoners saying his name and his cell number, and believed he was under threat, but did not know why. The SO noted that Mr Mason would not come out of his cell, but had been eating, as prison staff were taking food to his cell.

33. On 8 November, an officer noted that Mr Mason attended a video link for an appearance at Nottingham Crown Court and was further remanded for three weeks. The officer noted that there were no concerns raised.

34. On 18 November, Mr Mason's partner called the prison and told an officer that Mr Mason had heard that boiling water mixed with sugar was going to be thrown in his face. The officer rang prison staff on Mr Mason's wing, who told him they would go and check on Mr Mason. There is no evidence of a welfare check taking place.

35. A SO referred Mr Mason to the Mental Health Team. The referral form states that 'staff on C-wing have reported that Mark [Mr Mason] may be hearing voices, he appears to be paranoid that others on the wing are going to assault him however he cannot confirm who or why.'

36. On 22 November, an officer noted that Mr Mason refused to attend a legal visit by video link. The officer did not record the reason for Mr Mason's refusal.

37. On 27 November, Mr Mason's partner called the prison and told an officer that Mr Mason would not come out of his cell, as prisoners were walking past his door saying, 'get some sugar and a kettle, this is for Mason'. She asked for staff to carry out a welfare check. There is no evidence of a welfare check taking place.

38. On 29 November, an officer noted that Mr Mason attended a video link meeting with his legal team, in preparation for a court appearance at Newcastle Crown Court on 3 February 2023, where he was due to be sentenced. The officer noted that Mr Mason raised no concerns or issues.

39. Later that day, Mr Mason's partner rang the prison and spoke to Officer A and told her that Mr Mason needed to move wings, as he was under threat. Officer A called C Wing and spoke to Officer B, who told her that they were aware of Mr Mason's requests and were dealing with them.

40. Officer B then conducted a welfare check on Mr Mason. He told Mr Mason that his partner had called the prison and was concerned about him. Mr Mason replied that he was ok and that his partner just worried a lot about him. Officer B noted that he asked Mr Mason if he was under threat at all, and he said no, but he heard people at his door asking him what he was in for.

41. Officer B noted that Mr Mason's cellmate then said Mr Mason was just paranoid. Officer B asked Mr Mason why he was worried about being on the wing, and Mr Mason replied he was not. As there was no evidence that Mr Mason was under threat and staff thought he was paranoid, a wing move was not facilitated.

42. Officer A noted that she called Mr Mason's partner back, who was unhappy that Mr Mason could not be moved right away. Officer A noted that Mr Mason's partner told her that Mr Mason's legal team had written letters to Durham saying that Mr Mason needed to move wings (Durham told us that they had not received any such letters).

43. On 30 November, Mr Mason made several telephone calls to his partner. The investigator listened to the telephone calls between Mr Mason and his partner. (While prisoners' calls are recorded and a proportion listened to by staff to check for illicit content, there is no evidence that staff had listened to any of Mr Mason's calls before his death.) Mr Mason told his partner that his cellmate had got something to smoke from another prisoner, but he had not got any. She was annoyed by this and said that Mr Mason would be left with nothing due to 'double bubble', Mr Mason repeated that he did not get anything. ('Double bubble' is prison slang: when you

borrow something from another prisoner you are expected to give at least double back.)

44. Mr Mason's partner told Mr Mason she would ring the prison the following day and ask for him to be moved to another wing. Mr Mason told her that he did not collect his lunch or go to prison visits as 'they' were on the landing. ('They' appears to be a reference to the prisoners who Mr Mason believed were threatening him.) Mr Mason told his partner that prison staff had not heard anything about him being under threat and thought it was all in Mr Mason's head.

45. On 1 December, Mr Mason telephoned his partner on many occasions. During these calls his partner said she was frustrated because she was having to call the prison every day about Mr Mason being under threat. Mr Mason told her that he heard prisoners asking if 'Mason is still on the wing'.

46. Mr Mason said to his partner, 'I don't want to do something stupid'. She responded saying 'you best not kill yourself or nowt'. Mr Mason said that he would not.

47. Mr Mason's partner tried to encourage Mr Mason to make a mental health/GP referral. Mr Mason said he could not leave his cell. His partner said that he left his cell on a Friday to order his canteen (items from the prison shop), and therefore could make the referral then. Mr Mason was resistant to this suggestion.

Events of 6 and 7 December 2022

48. On 6 December, a nurse saw Mr Mason for a mental health assessment following wing staff's referral. Mr Mason initially refused to leave his cell because he was scared of being attacked but then agreed to go to an interview room when an officer accompanied him.

49. The nurse noted that Mr Mason was low in mood and very fearful that someone would attack him. He said that due to threats he had received when he arrived on C Wing, he was paranoid that something was going to happen to him and wanted to be moved somewhere safer. He said that he always had thoughts of self-harming but that he had had these thoughts for some years and had always managed not to act on them because of the love of his family and partner.

50. The nurse noted that there was no evidence of hallucinations, that Mr Mason was clean and tidy, and that he engaged well with good eye contact. She assessed that Mr Mason was not psychotic but was fearful and anxious. She said that she would refer him to a GP to discuss his low mood and anxiety, which he was happy with. She also offered him a referral to Rethink for anxiety management, but he declined. She noted that after the assessment, she spoke to an officer who said that he would discuss whether Mr Mason could be moved. She discharged him from the mental health team. The nurse made comprehensive notes in Mr Mason's medical record following the assessment.

51. On 7 December, Mr Mason telephoned his partner many times. During these conversations Mr Mason told his partner that his cellmate had not heard other prisoners calling Mr Mason's name.

52. At around 5.20pm, Mr Mason telephoned his partner again and told her that his cellmate had been released and he was worried about who his new cellmate would be. Mr Mason said that his new cellmate might be 'their' friend ('their' appears to be a reference to the prisoners who Mr Mason believed were threatening him).

53. Mr Mason told his partner that his cellmate was content to have their cell locked all day, and he was worried that a new cellmate might not want to do the same. Mr Mason told his partner that he had asked staff for a wing move and she asked him to wait a couple of days for prison staff to arrange the wing move. (An intelligence report confirms that Mr Mason told staff he was frightened and had requested to move off C Wing.)

54. Mr Mason called his partner again at 6.51pm. He sounded a bit agitated and was still concerned about who his new cellmate would be. Mr Mason told his partner that 'they [other prisoners] will start shouting soon'.

Events of 8 December 2022

55. On 8 December, an operational support grade (OSG) noted that he started his morning checks at 5.00am, and when he came to Mr Mason's cell and looked through the observation panel, he saw movement on the bed so assumed Mr Mason was fit and well. The OSG noted that over the previous week, Mr Mason had not activated his cell bell during the night and had raised no concerns.

56. CCTV footage shows that at 5.50am, Mr Mason turned on the light in his cell. From a review of the CCTV, there is no indication that he used his cell bell that morning (when a cell bell is pressed, a light is activated outside the cell but no cell bell light could be seen on the CCTV).

57. At 7.14am, Mr Mason telephoned his partner, who was surprised that he called her so early. The call lasted for three minutes and 40 seconds. Mr Mason sounded subdued but did not say anything that would have caused his partner concern. Mr Mason ended the call saying he would phone his partner back once she had woken up properly.

58. CCTV footage shows that at 9.30am, an officer arrived at Mr Mason's cell, along with Mr Mason's new cellmate. The officer opened the cell door, and the prisoner moved to go into the cell, but then turned to the officer and said something. The officer noted that on looking into the cell, he could see Mr Mason with a ligature around his neck, which had been secured to the bed frame. He radioed a code blue medical emergency, shouted to alert prison staff and then entered the cell. Two other members of prison staff responded and entered the cell.

59. The officer cut Mr Mason's ligature, put Mr Mason on the floor and began CPR. He said that Mr Mason had a cold hand, grey complexion, and blood stains around his mouth. Staff fetched a defibrillator and attached it to Mr Mason. It advised and delivered one shock but after that advised no shock and to continue with CPR.

60. At 9.34am, a nurse attended the cell and assisted with CPR. She told the investigator that Mr Mason had no pulse.

61. At 9.49am, paramedics arrived at Mr Mason's cell. At 9.51am, prison staff carried Mr Mason out onto the landing where paramedics took over chest compressions, and the nurse continued maintaining Mr Mason's airway, providing ventilations and suction.

62. After discussions between healthcare and paramedics CPR was stopped. Mr Mason was pronounced dead at 10.07am.

63. The police investigated Mr Mason's death. They said that two other ligatures were found in Mr Mason's cell which appeared to be created from the same bed sheet. These ligatures had small amounts of blood on them. The police said this could indicate that Mr Mason made several unsuccessful attempts to hang himself.

Contact with Mr Mason's family

64. On 8 December, the prison appointed two family liaison officers. That afternoon, they visited the home of Mr Mason's partner. She was not at home, so they contacted her by telephone, and told her that Mr Mason had died.

65. The family liaison officers kept in contact with Mr Mason's partner over the following days, offering support and advice.

66. The prison contributed to the costs of Mr Mason's funeral in line with national policy.

Support for prisoners and staff

67. After Mr Mason's death, a prison manager 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 Mason'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 Mason's death.

Post-mortem report

69. The post-mortem report concluded that the cause of Mr Mason's death was pressure to the neck caused by hanging.

70. Toxicology results found no drugs or alcohol in Mr Mason's system.

Findings

Assessment of Mr Mason's risk of suicide and self-harm

71. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, provides guidance to staff on identifying prisoners who might be at risk of suicide and self-harm. It lists the risk factors and triggers that might increase a prisoner's risk and sets out the procedures (known as ACCT) that staff should follow when they identify a prisoner at risk of suicide and self-harm.

72. Mr Mason was not assessed as being at risk of suicide or self-harm while he was at Durham so was never monitored using ACCT. He possessed some of the risks and triggers for suicide and self-harm listed in PSI 64/2011, including being charged with a violent offence and being fearful of violence or intimidation and he had a history of suicide attempts. Whether or not his fears about his safety on C Wing were justified, they meant that he barely left his cell and had no support network in prison beyond his cellmate and, perhaps, staff. If his fears for his safety were unfounded, the policy notes that irrationality or being out of touch with reality also raises the risk of self-harm.

73. On 6 December, during a mental health assessment, Mr Mason told the nurse that he had had thoughts of self-harm for some years but had not acted on them because of his family and partner. The nurse told the investigator and clinical reviewer that she had checked Mr Mason's medical records before carrying out the assessment and had not seen anything of concern, including no references to previous suicide attempts. However, Mr Mason's medical records state he had a history of attempted suicide by hanging, use of carbon monoxide and overdose. This information, had it been accessed, would have added to the overall picture of the risk Mr Mason may have posed to himself.

74. After the assessment, the nurse did discuss Mr Mason's concerns about his safety with a wing officer. However, she did not tell the officer that Mr Mason had ongoing thoughts of self-harm.

75. The clinical reviewer considered that given Mr Mason's presentation at the mental health assessment and his persistent thoughts of self-harm, this was a missed opportunity for the mental health team to offer him further support and assessment. She also found that the failure to identify that Mr Mason had a history of suicide attempts and to pass on information to wing staff about his thoughts of self-harm were also missed opportunities to manage Mr Mason's risk to himself.

76. We recommend:

The Head of Healthcare should ensure that all members of the Mental Health Team:

- **thoroughly check medical records prior to conducting assessments, so that relevant historic information forms part of any consideration and management of a prisoner's risk of suicide and self-harm; and**

- **understand the importance of communicating risk information to relevant members of prison staff.**

Mr Mason's location

77. Population management in prisons is complex, with many factors needing to be considered. The safety of prisoners is one of these factors. However, moving a prisoner takes up time and resources, and so the reason for moving a prisoner must be legitimate.

78. It is evident from Mr Mason's telephone conversations with his partner, his reluctance to come out of his cell, and from conversations he had with prison and healthcare staff, that Mr Mason sincerely believed that he was under threat from other prisoners. He, and his partner, asked for a move from C Wing.

79. However, other than Mr Mason's account, there was no evidence available to staff that he was under threat. Additionally, Mr Mason did not name the prisoners who he believed were threatening him, and so prison staff could not investigate the matter further. Therefore, prison staff were not required to move Mr Mason.

80. Prison staff referred Mr Mason for a mental health assessment after staff and Mr Mason's cellmate raised concerns that Mr Mason was paranoid. We consider that staff responded appropriately in the circumstances.

Clinical care

81. The clinical reviewer concluded that the mental health care Mr Mason received at Durham was not equivalent to that which he could have expected to receive in the community. She found that there were a number of missed opportunities to assess and manage the risk Mr Mason posed to himself, and also to communicate important information about Mr Mason to other staff within the prison.

82. The clinical reviewer made a number of other findings and recommendations on issues unconnected to Mr Mason's death, which the Head of Healthcare will want to address.

Emergency response

Delay in calling an ambulance

83. PSI 03/2013, *Medical Emergency Response Codes*, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate, and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately. The PSI says that the person using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use in the triage process.

84. On 8 December, at 9.30am, when the medical emergency code blue was called, an officer was in the control room handling the radio traffic. She was accompanied by an OSG, who was handling the telephone.

85. The OSG told us the procedure for calling an ambulance at Durham requires control room staff to have specific information about the prisoner and their condition before they can call the ambulance service. He said that sometimes the ambulance service will insist they are provided with this information before they send an immediate response ambulance, which will usually arrive within 15 minutes.

86. The OSG told us that when they received the code blue over the radio, limited information about Mr Mason or his condition was provided, so the officer radioed staff who were with Mr Mason for further information but received no response. The OSG told us that there was a lot of radio traffic at the time and staff were telephoning the control room on unrelated matters, which caused communication problems. The OSG told us that eventually a staff member radioed the control room providing the relevant information and he then called the ambulance service.

87. This resulted in a five minute delay after the code blue was called. An ambulance was then dispatched to the prison. We are unable to say whether this delay affected the outcome for Mr Mason but we know that in a medical emergency, a delay of a few minutes could be critical.

88. We recommend:

The Prison Group Director and Governor should examine in detail their processes for acquiring an urgent ambulance, in conjunction with their partners in the local ambulance service.

Governor to note

Welfare checks and Prison-NOMIS case notes

89. PSI 23/2014 *Prison-NOMIS (Prison National Offender Management Information System),* states all staff who have contact with a prisoner and who have access to Prison-NOMIS must update case notes on a regular basis.

90. Prison-NOMIS shows that Mr Mason's partner contacted the prison on five occasions raising concerns about Mr Mason's safety. However, on three of these occasions: 17, 27 and 29 November, staff did not make a note on Prison-NOMIS confirming that a welfare check had taken place, and so on these occasions staff did not report on Mr Mason's welfare. (In his statement, Officer B said he did conduct a welfare check on 29 November.)

91. As stated in PSI 23/2014 prison staff should update Prison-NOMIS case notes after every welfare check. This would have ensured that information about Mr Mason was effectively shared with other staff to inform assessment and management of risk. The Governor will wish to consider this learning.

Inquest

92. At the inquest, heard from 15 to 26 September 2025, the jury concluded that Mr Mason, “died of a ligature which was self-inflicted but his probable intent cannot be determined”.

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