Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Mason, a prisoner at HMP Liverpool, on 10 September 2025

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



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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 Mason was found dead in his cell at HMP Liverpool on 10 September 2025. He was 44 years old. He died of synthetic cannabinoid toxicity. I offer my condolences to Mr Mason's family and friends.

Mr Mason had a long history of drug use in the community and during previous prison sentences. He had only been at Liverpool for two days before he died. The clinical reviewer concluded that Mr Mason's clinical care was equivalent to that which he could have expected to receive in the community.

Like many prisons, Liverpool has had difficulty controlling the ingress of drugs. The Governor has introduced several measures to try to reduce supply. However, this is a constantly evolving challenge and there is always more to be done to identify and address weaknesses.

Nationally, there has been increasing awareness and concern about the high toxicity of synthetic cannabinoids, which are often mixed with other drugs. Liverpool has established several methods of engaging with prisoners about substance use and I encourage staff to use those mechanisms to alert prisoners to the significant risks of using drugs potentially laced with these substances.

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 **April 2026**

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Summary

Events

1. On 8 September 2025, Mr Carl Mason was sentenced to 30 months in prison for theft offences and breaching a criminal behaviour order. He was taken to HMP Liverpool. Mr Mason had also breached a previous release licence.

2. Mr Mason had a history of alcohol and substance use including crack cocaine, cannabis and psychoactive substances (PS). Since 2022, Mr Mason had served several short sentences for drug related offences.

3. During his initial prison screen and healthscreen, staff identified no immediate risks or issues. Mr Mason met a substance use recovery worker who provided him with harm minimisation advice and information on the risks of using drugs in prison.

4. On 10 September, Mr Mason completed his prison induction and moved to a single cell on K Wing. At 4.30pm, Mr Mason collected his dinner, and at 4.39pm, an officer locked him into his cell for the night.

5. At 8.51pm, an officer completing a routine check of prisoners discovered Mr Mason laying unresponsive on his floor. At 9.00pm, the officer radioed a medical emergency and other officers and nurses responded and they started cardio-pulmonary resuscitation (CPR). Paramedics arrived and continued resuscitation efforts but at 9.21pm, they pronounced life extinct.

6. A post-mortem concluded that Mr Mason died of synthetic cannabinoid toxicity.

Findings

7. The clinical reviewer concluded that Mr Mason's clinical care was equivalent to that which he could have expected to receive in the community. They made no recommendations. Mr Mason's drug use was appropriately assessed, and he was given advice about the dangers of using drugs in prison.

8. We are satisfied that the prison is actively addressing both reducing demand and preventing the supply of illicit drugs.

9. When an officer first discovered Mr Mason, he did not immediately radio a medical emergency. This meant there was a delay of at least eight minutes before an ambulance was requested. While this did not affect the outcome for Mr Mason, who had likely been dead for some time, this may be crucial in the future.

10. The communication between the control room officer to staff at Mr Mason's cell and the ambulance service was very good.

11. We make no recommendations.

The Investigation Process

12. HMPPS notified us of Mr Mason's death on 10 September 2025.

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

14. The investigator visited Liverpool on 1 October. She obtained copies of relevant extracts from Mr Mason's prison and medical records. She watched CCTV footage, and body worn video camera (BWVC) recordings and listened to staff radio communications from 10 September. Further information was obtained from North-West Ambulance Service. In February 2026, a second investigator, was assigned to complete the investigation.

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

16. On 5 November, the first investigator and clinical reviewer interviewed five members of staff and one prisoner at Liverpool. The first investigator interviewed a further member of staff on 14 November. On 23 February 2026, the second investigator interviewed the officer who discovered Mr Mason.

17. We informed HM Coroner for Liverpool and The Wirral of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Mason's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Mason's sister asked why Mr Mason was not monitored more closely at Liverpool given his history of using drugs in prison and especially in the light of him being resuscitated at a previous prison in March 2025. She also asked the investigator to interview a prisoner in the cell next door to Mr Mason. The investigator interviewed the prisoner, and we have answered her question in this report.

19. Mr Mason's sister received a copy of the initial report and did not identify any factual inaccuracies.

20. The prison also received a copy of the report and did not identify any factual inaccuracies.

Background Information

HMP Liverpool

21. HMP Liverpool is a category B local reception and remand prison for adult men. Spectrum Healthcare Limited provides primary healthcare services. Mersey Care National Health Service Foundation Trust provides mental health services. Spectrum Community Health delivers clinical substance misuse services in partnership with Change, Grow, Live (CGL) who are sub-contracted to deliver one-to-one and group-led psychosocial support.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Liverpool was in August 2025, Since the previous inspection in July 2022, Liverpool had been recategorised back to being a reception prison. Inspectors found the change in population to a more unstable group of prisoners was partly responsible for a reduction in safety, respect and purposeful activity.

23. Inspectors found the prison was being continuously targeted by serious organised crime gangs using drones to deliver drugs and other contraband. Leaders worked hard to reduce the drug problem and close liaison with the police and other agencies resulted in many drug parcels being successfully intercepted. The security team worked well to manage a significant amount of intelligence. The Governor had funded a dedicated drug strategy lead from his local budget, and the revised drug strategy demonstrated several elements of innovative and good practice. Despite this the scale of the problem was overwhelming for local leaders to manage. Significant investment from the prison service to improve the security of windows and exercise yards was required to tackle the vulnerability of the prison to the ingress of illicit items.

24. Inspectors noted there were not enough activities and prisoners were locked up for too long. Prisoners said that the limited regime often led to drug use and almost half of prisoners surveyed said it was easy to get illicit drugs. Inspectors found the drug and alcohol recovery team provided a comprehensive, flexible and responsive service, offering a wide range of one-to-one and group interventions tailored to the needs of the population and delivered on the wings.

Independent Monitoring Board

25. 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 2024, the IMB reported that the prison had made positive progress in the previous year. However, reduced staff resources had impacted adversely on provision of the regime and there was insufficient key worker contact. Prisoners spent very little time out of their cells and it was difficult for staff to develop relationships with them, due to the high turnover of prisoners.

26. The Board noted that a significant quantity of illicit items, such as drugs and mobile phones, had been found, which caused disruption across the prison. They were concerned that 99 drones had been spotted during the year, but the replenishment of drugs and other contraband suggested that drones were not the only significant route for trafficking illicit items. Staffing issues had also affected mandatory drug testing (MDT) and there was a continuing increase in the availability of illicit drugs.

Previous deaths at HMP Liverpool

27. Mr Mason was the 18th prisoner to die at Liverpool since September 2022. Of the previous deaths, five were self-inflicted, nine were due to natural causes, two were drug related and one was unascertained. There were no similarities between this and previous investigations. Since Mr Mason's death and up to the end of February 2026, there have been two more deaths at Liverpool, both due to natural causes.

Psychoactive substances (PS)

28. The term psychoactive substances is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazenes) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

29. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

Background

30. On 2 September 2025, Merseyside Police arrested Mr Carl Mason for stealing alcohol from a shop. On 8 September, Mr Mason was sentenced to 30 weeks imprisonment for theft and breaching a criminal behaviour order and was taken to HMP Liverpool. A previous release licence was also revoked.

Substance use

31. Mr Mason had a long history of alcohol and poly-substance use dating back to 2012, including crack cocaine, cannabis and psychoactive substances (PS). Mr Mason had served several short prison sentences for drug related offences since 2022. He had mental capacity and was fully aware of the risks associated with drug use. Mr Mason's records show a pattern of using PS in prison and getting into debt. Attempts were made to support Mr Mason with his drug use issues, but he told staff it was his choice to live his life with drug use, and he lacked the willingness and motivation to sustain change.

32. In March 2025, Mr Mason was found unresponsive in his cell in HMP Altcourse, and staff successfully revived him using a defibrillator and naloxone (an emergency medication used to rapidly reverse life-threatening effects of opioid overdose). On 3 July, he was released on licence.

Mental health

33. Mr Mason had no mental health diagnosis and had not been treated for a mental illness either in the community or in prison. There were occasions when Mr Mason said to prison healthcare staff that he had anxiety and depression. Assessments completed in November 2024 and February 2025 showed that he had low level depression, but no treatment was required.

Physical health

34. When he was 14 years old, Mr Mason suffered back and nerve damage following an accident and he was prescribed pain relief (pregabalin, a highly tradeable drug within prison). He received consistent healthcare input when in prison and continued receiving his pain relief medication. He was not allowed to have his medication in his possession and had to collect it daily from the medications hatch.

8 September

35. At around 5.00pm, Mr Mason arrived at Liverpool. An officer completed Mr Mason's reception screening and First Night Induction Booklet. He recorded there were no immediate risks and concerns and that Mr Mason had tried to make a phone call from reception, but it was unanswered. (There is no information as to who he tried to call or of him being offered another call). In the duty governor section of the induction booklet, no record is made of Mr Mason's substance use and he was not

referred to substance use services. There is no signature or name of who completed this section.

36. Staff completed Mr Mason's Cell Sharing Risk Assessment (CSRA, to assess the risk of harm to a potential cell mate were a prisoner to share a cell). This concluded that he posed a high risk and was only allowed to share a cell with someone with the same ethnicity and sexuality.

37. A nurse completed an initial healthscreen with Mr Mason. All his clinical observations were normal. Mr Mason said that he had a history of cannabis use and did not drink alcohol. The nurse referred Mr Mason to a GP to review his pain relief medication.

38. A GP, reviewed Mr Mason's prescription for pain relief and he prescribed a single dose of pregabalin pending a pharmacy review. (A pharmacy technician completed this the next day and continued the prescription). Mr Mason was not allowed to have this medication in possession.

39. Mr Mason moved to a double cell on B Wing, the induction wing, but he was the only occupant.

9 September

40. At around 9.00am on 9 September, an officer met Mr Mason and completed an initial key worker session. She explained the key worker scheme and told Mr Mason that he would be assigned a regular key worker when he had completed his induction. The officer ensured Mr Mason had a form to apply for phone numbers to be added to his prisoner telephone account and that he knew how to use the kiosk to order items from the prison shop and make applications.

41. After lunch, as part of his induction, a recovery motivator from Change Grow Live (CGL – drug and alcohol substance use services) met with Mr Mason and explained what services were available to him. She gave him general advice about harm minimisation, the risks associated with taking drugs in prison and issues around accruing debt.

42. At 3.20pm, a nurse completed Mr Mason's secondary health assessment to identify any significant family medical history, long-term conditions and necessary vaccinations. Mr Mason said he had no long-term conditions but reported a history of musculoskeletal pain, caused by the accident in his childhood. The nurse created a care plan to review Mr Mason.

Events on 10 September

43. The investigator watched Closed Circuit Television (CCTV) footage, body worn video camera (BWVC) footage and listened to staff radio communications of the events of 10 September. She also obtained information from staff statements and interviews and from North-West Ambulance Service. The following account has been taken from all sources.

44. At around 11.00am on 10 September, Mr Mason moved to a single cell on K Wing, a standard wing.

45. At around 4.30pm, Mr Mason left his cell to collect his evening meal. He returned to his cell six minutes later. At 4.39pm, an officer locked his cell door for the night. Those prisoners who had been working during the day were allowed out of their cells for association between 6.00pm and 7.00pm.

46. At about 6.26pm, a prisoner appeared to be talking to Mr Mason through his door for about 20 seconds. At 6.34pm, the same prisoner spoke to Mr Mason through his door for about a minute and a half. The prison identified the prisoner, but he was released shortly after Mr Mason's death, and we did not interview him.

47. At around 7.02pm, an officer looked through Mr Mason's observation panel as part of a routine check of prisoners (known as the evening roll count). In her interview, the officer said she could not specifically remember what Mr Mason was doing but all the prisoners she checked were alive and well.

Emergency response

48. At 8.51pm, the night patrol officer, looked through Mr Mason's observation panel for 13 seconds during a routine check of prisoners. The officer returned to the cell 45 seconds later and knocked on the door. After a few seconds he turned the cell light on and tried to look into the cell from different angles. After almost three minutes, the officer moved away from the door. At 8.56pm, the officer radioed for Oscar 2 (a radio call sign for the assistant operational manager) to attend K Wing. He did not give any information or context to the request and there was no urgency in his voice. An officer, Oscar 2, who was undertaking duties in another part of the prison, responded and said he would be five to ten minutes.

49. At 8.58pm, the officer radioed for the duty nurse to attend K Wing, saying he might need the emergency response nurse as he was unsure if a prisoner was breathing. He did not give any specific information and did not radio a medical emergency code.

50. A nurse, who was the duty nurse, was in the surgery at the bottom of K Wing. In response to the officers' radio transmission, she shouted up to him and asked if there was an issue. The officer told her a prisoner was on the floor, and he did not know if he was breathing. The nurse told the officer to radio a code blue (used to indicate a prisoner has either stopped or is having difficulty breathing) and ran up the stairs to the cell. She saw another officer and asked him to collect her medical emergency bag, which he did. At around 9.00pm, the officer radioed a code blue. Operational Support Grade (OSG), the communications officer, requested an ambulance immediately and staff responded very quickly to the emergency radio call.

51. When staff entered Mr Mason's cell, they found him on the floor. The nurse observed Mr Mason had vomit on his chest and was cold, but there were no signs of rigor mortis (stiffening of the body after death). Staff immediately started CPR. BWVCs were not activated until CPR had started. The nurse attached a defibrillator to Mr Mason, but no shockable rhythm was detected. Two officers continued CPR until paramedics arrived.

52. At 9.08pm, paramedics arrived. CPR continued while they assessed Mr Mason but at 9.21pm, paramedics declared life extinct.

53. After Mr Mason had died, staff found a tampered vape, vape capsules and paper in his cell, often an indicator of drug use.

Contact with Mr Mason's family

54. The prison appointed a senior prison manager, as family liaison officer. Mr Mason had given the name of his partner as his next of kin when he arrived at Liverpool but did not give an address or telephone number. At the time of his arrest, Mr Mason was recorded as no fixed abode. The police held the address of his former partner but as she was protected by a restraining order it was decided not to visit her.

55. The prison identified Mr Mason's sister's contact details from an application he had made to add numbers to his prisoner telephone account. The senior prison manager and another member of staff visited Mr Mason's sister in person the next morning and broke the news that he had died. They offered their condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Mason's funeral.

Support for prisoners and staff

56. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

57. After Mr Mason's death, duty governor, 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.

58. 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. Samaritans and Listeners were quickly notified of the death and were available if requested to provide support to prisoners.

59. Mr Mason's son, who was in a different prison, was supported by staff there.

Post-mortem report

60. The pathologist gave the cause of Mr Mason's death as synthetic cannabinoid toxicity. Pregabalin, which had been prescribed to Mr Mason, was detected at a therapeutic level.

Findings

Mr Mason's substance use

61. Mr Mason had a long history of using PS, crack cocaine and cannabis. His medical records show that while he was in prison, staff tried to support Mr Mason with his drug use issues, but he was unable to sustain a life without drugs and was often reluctant to engage with drug support services.

62. Post-mortem and toxicology results found that Mr Mason had used PS (synthetic cannabinoids) sometime before his death. When Mr Mason was found unresponsive, he had a tampered vape and capsules.

63. When he arrived at Liverpool, a CGL recovery worker met Mr Mason as part of the induction process. She explained what services were available to him and gave Mr Mason general advice about harm minimisation and drug use in prison.

64. The clinical reviewer found the initial reception healthscreen was comprehensive and that Mr Mason received a good standard of care. The clinical reviewer did not make any recommendations.

65. Mr Mason had been at Liverpool just over 48 hours before he died. He was not subject to any checks aside from routine ones during that time, as staff had not identified him to be under the influence. While it is concerning that he was able to obtain PS so quickly, we are satisfied that his drug use was appropriately assessed and he was given information about the dangers of using drugs.

Measures to reduce demand and supply of illicit substances

Drug strategy

66. Following Mr Mason's death, and a previous drug related death in December 2024, we interviewed the Heads of Drug Strategy and Security to understand the steps the prison had taken to address the high availability of drugs, an issue highlighted in the most recent inspection and IMB reports.

67. The Head of Drug Strategy, said that the Governor had prioritised reducing demand and supply of drugs by designating the Head of Drug Strategy as a dedicated post, and funding it from a local budget (rather than allocating it as a task attached to another functional role). This approach enabled drug reduction strategies to be high on the agenda of every department. For example, it is considered when reviewing all policies, such as training, pay, incentives and reducing reoffending.

68. Formal multidisciplinary meetings are attended by heads of functions and there is day to day liaison with wing custodial managers to ensure that action plans are in place to manage and mitigate the risks around prisoners identified as problematic. There is a focus on data from across the prison to easier spot trends or other associated risks such a self-harm or bullying on specific wings. The overarching strategy document is reviewed quarterly.

69. The prison's intention is to adopt a rehabilitative, rather than a punitive response to drug taking, so there has been a focus on increasing purposeful activities and alleviating boredom by introducing a new core day. However, their ability to provide

a consistent regime is often compromised by staffing issues, notably a high level of sick leave.

70. A key action to reduce demand for drugs was relaunching the Incentivised Substance Free Living (ISFL) unit, with a greater use of intelligence and input from the security team to select suitable prisoners.

71. One of the challenges Liverpool faces is that as a reception and remand prison in a city, many prisoners are not ready for recovery, or are at the beginning of abstinence, so there is still a demand for illicit drugs. It is difficult to combat this with the high turnover of prisoners. Cannabis and PS are the most prevalent drugs. Use of the former was institutional among some prisoners, who were second or third generation users in their households and did not see it as a problem or something that they should necessarily stop doing.

72. The prison has a '*First Responder: Under the Influence'* protocol which lists the actions to be taken when a prisoner is suspected to be under the influence of illicit substances. Healthcare staff examine every reported person and add them to a ledger. The substance misuse service meets those listed within 24 hours.

73. Due to staffing issues, there are limitations on the number of mandatory drug tests but the prison manages to meet its target. In April 2025, 42 tests were taken and 48% were positive (by December the number of positive tests had reduced to 35%). Of those, 14% were positive for PS (it is noted that there is a long window of detection for PS and cannabis which can stay in the system for up to 14 days). Liverpool introduced an improvement plan to increase the level of suspicion testing. As of January 2026, staff completed 26 suspicion tests (an increase from five in April 2025). The results of these mandatory drug tests were not known at the time of writing. Liverpool also now have two ringfenced officers who are detailed as part of the drug strategy team to support prisoners found under the influence.

Security

74. The Head of Security said that illicit drugs enter Liverpool through many routes but there was a particular problem with drones. The prison has a quarterly meeting with Merseyside Police, who provide information and support on trafficking issues, including several drone operations in the prison. Staff also work with the local community to get feedback on matters such as identifying vulnerable areas of the prison perimeter where drugs are thrown over the wall.

75. Another action to address the problem of drones was a reconfiguration of wings. Prisoners in the main population on opiate substitution treatment have been moved to a dedicated unit with enhanced physical security, as the cells have window grills. The prison has applied for funding to install window bars on other wings.

76. As with other prisons, drugs are also trafficked through mail, parcels, visits and staff corruption. Prisoners now receive photocopied mail, and all parcels are X-rayed and passed by drug detection dogs. A barcode system is in place for legal correspondence. Although detection dogs are not available to monitor all visits, staff can request additional support if intelligence is received about potential trafficking.

77. There is an enhanced gate system with airport style X-ray machines. All staff are now searched on arrival, with additional ad hoc searches by external specialists. The Head of Security has increased the number of lockdown searches of cells, with around four in a 12-month period.

78. On average, the prison receives around 25 intelligence reports per day. High-risk intelligence is reviewed immediately by the duty governor. All other information is initially read within 24 hours and fully assessed within seven days.

79. We are satisfied that the prison is actively addressing both reducing demand and preventing the supply of illicit drugs.

Governor to Note

Reception process

80. When Mr Mason arrived at Liverpool the First Night Induction booklet was not completed accurately. This did not impact Mr Mason's time at Liverpool, as he met with a recovery worker from CGL the day after he arrived. However, the Governor will want to ensure accurate information is recorded about a prisoners' risks and needs when they first arrive to ensure appropriate referrals are made to provide timely and targeted support.

Medical emergency code

81. PSI 03/2013, *Medical Emergency Response Codes*, sets out the actions staff should take in a medical emergency. It requires all prisons to have a medical emergency response code protocol in place 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 are alerted, the correct equipment is brought, and an ambulance is called immediately.

82. An officer did not follow local procedures when he first identified that Mr Mason was unresponsive on the floor of his cell. He did not radio a code blue medical emergency and the information he shared over the radio was not concise. There was a delay of around eight minutes before he radioed a code blue and he only did so on the instruction of the duty nurse. Liverpool told us that they had looked into the officers' actions and concluded that they did not meet the threshold for a disciplinary investigation. However, when we interviewed the officer in February 2026, he told us that no one had spoken to him about his actions that night. We remain unconvinced that he is clear about his responsibilities in a medical emergency.

83. The delay did not impact on the outcome for Mr Mason, who had signs that he had been dead for some time, but we know that any delay may be critical in an emergency, and staff should radio for help at the earliest opportunity. We bring this issue to the Governor's attention.

Body Worn Video Cameras

84. PSI 04/2017, *Body Worn Video Cameras (BWVC),* requires prison staff to use BWVCs during any reportable incident, including medical emergencies. It requires staff to start recording at the earliest opportunity, to maximise the material captured by the camera. BWVC's are an important source of evidence for PPO investigations, and wider learning for prisons following an incident.

85. Officers responding to the medical emergency did not activate their BWVCs until after resuscitation efforts started. An officer said he felt shocked by events and simply forgot. The Governor will want to remind staff BWVCs should be activated at all reportable incidents.

Naloxone

86. There is no evidence that prison or healthcare staff considered administering naloxone (although Mr Mason had not taken opioids, staff at the time would not have known this and administering the drug would not have caused any significant harm). The Head of Drug Strategy said that since August 2024, 119 staff have been trained to administer nasal naloxone. The officer had never heard of naloxone and a union representative present during his interview said that the union were pushing back against its introduction as officers are not renumerated or sufficiently trained to administer it. A nurse said that she believed Mr Mason had already died when he was discovered. Naloxone is a potentially lifesaving drug. The Governor will want to ensure that proactive talks with the union about naloxone introduction continue and staff awareness is increased.

Good practice

Communication with the ambulance service

87. An OSG followed national guidance and requested an ambulance immediately when the officer radioed a code blue. Radio transmissions of the incident, and the telephone call between the OSG and North-West Ambulance Service, demonstrated good practice. While simultaneously in communication with officers at Mr Mason's cell, she was directive and provided clear and concise information to the ambulance service which resulted in an emergency ambulance being dispatched immediately. Paramedics arrived within eight minutes of the emergency call. The Governor will want to ensure the OSG is made aware of our finding and ensure all staff working in the communications room are trained to the same level.

Inquest

88. The inquest into Mr Mason's death concluded on 3 November 2026, with a finding that the death was drug-related.

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