Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Mason, a prisoner at HMP Holme House, on 7 October 2019

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

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

T l 020 7633 4100

Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

OGL

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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Lee Mason died on 7 October 2019 in North Tees Hospital, after being found hanging in his cell at HMP Holme House on 30 September. Mr Mason was 38 years old. I offer my condolences to Mr Mason's family and friends.

Mr Mason was convicted of an assault against his then-partner. During the incident, he made a serious cut to his neck and then threatened to hang himself when he was arrested.

We are concerned that prison staff did not identify that he had a number of risk factors. Instead, they relied on Mr Mason's presentation and assurances that he had no thoughts of harming himself.

We are also concerned that there may have been a delay in calling an ambulance, a concern we have previously raised with Holme House.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **October 2021**

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Summary

Events

1. Mr Lee Mason was remanded to HMP Durham in June 2019 charged with an assault against his then-partner. He cut his own neck during the assault and arrived in prison with a self-harm warning form, noting that he had also threatened to hang himself. On 1 August, Mr Mason was sentenced to 12 months in prison for malicious wounding. He told staff his sentence was less than he had been expecting.

2. Mr Mason was transferred to HMP Holme House on 7 August, which meant that his former partner could visit more easily. The escort papers that accompanied him did not contain any self-harm warnings and reception staff assessed that he was not at risk of suicide or self-harm.

3. On 14 August, Mr Mason asked to speak to someone about having suffered from anxiety and depression before coming into prison. He was referred for psychological therapy.

4. On 28 August, Mr Mason told his key worker that he was settling in well. He said he got on with his cellmate, his former partner remained supportive and continued to visit him and speak to him on the telephone.

5. On 10 September, Mr Mason was told that his father's address had not been approved for Home Detention Curfew (early release with a tag), and he would have to go to an Approved Premises.

6. On 24 September, Mr Mason was "distressed" and told his key worker that he had gone sick from work as he was feeling "extremely down". He said his former partner had not visited him for three weeks and he did not want to go to the Approved Premises as it was a long way from his family and where he had hoped to work, and he thought he would be back in prison in a few weeks.

7. On 27 September, Mr Mason saw a psychological wellbeing practitioner for an assessment. He said he did not feel up to being assessed that day as he was feeling "low" but asked for the appointment to be rescheduled. He said he had no thoughts of harming himself.

8. On 30 September, an officer unlocked Mr Mason's cell to let his cellmate back in from work, and found Mr Mason hanging. Staff provided first aid, and Mr Mason was transferred to hospital. He remained in intensive care until life support was withdrawn on 7 October. Mr Mason died that afternoon.

Findings

Assessment of risk

9. Prison Service guidance lists a number of risk factors for suicide and self-harm. Mr Mason had a number of these risk factors, but there was no formal assessment of risk that allowed staff to identify them.

10. Mr Mason denied having thoughts of suicide and self-harm when asked. However, there is no evidence that wing staff had any interactions with Mr Mason during his eight weeks at Holme House. This meant that staff were not in a position to gauge the risk he presented.

11. Although his key worker spoke to him, we consider that she did not give sufficient weight to evidence that he was feeling "extremely low" and there is no evidence that she communicated this to wing staff or considered opening an ACCT.

12. We do not say that an ACCT should definitely have been opened, but we would have expected to see more awareness that this might have been a possibility.

Mr Mason's healthcare

13. The clinical reviewer concluded that the healthcare Mr Mason received was equivalent to that which he could have expected in the community. He was awaiting a mental health assessment, which was within appropriate timescales.

Emergency response

14. When staff found Mr Mason was hanging, they provided immediate medical assistance.

15. We are concerned that there appears to have been a delay in calling an ambulance.

16. Emergency response healthcare staff do not carry keys. This did not seem to delay assistance to Mr Mason but could do so in future emergencies.

17. The clinical reviewer said that the efforts of staff who provided medical aid to Mr Mason should be acknowledged as an example of good practice.

Recommendations

- The Governor should ensure that prison staff are aware of the risk factors that might put prisoners at risk of suicide or self-harm and do not rely solely on how a prisoner behaves or what he says when assessing risk. This should include considering and recording the known risk factors of newly arrived prisoners.
- The Governor should encourage and enable wing staff to engage regularly and positively with the prisoners in their care.
- The Governor should ensure that:
  - all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies; and
  - the control room calls an ambulance immediately when an emergency code is used.
- The Governor and Head of Healthcare should ensure that arrangements for medical emergency responders do not cause delays in medical aid reaching prisoners in emergencies.

- The Governor and Head of Healthcare should ensure that this report is shared with Officer A, the prison paramedic, the healthcare team support worker and Nurse A (who all tried commendably to preserve Mr Mason's life) so they are aware of the Ombudsman's findings.

The Investigation Process

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

19. The investigator visited Holme House in December 2019. He obtained copies of relevant extracts from Mr Mason's prison and medical records.

20. The investigator interviewed seven members of staff at Holme House. NHS England commissioned a clinical reviewer to review Mr Mason's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. Mr Mason's cellmate was released from prison before the investigator had the opportunity to interview him. The investigator wrote to him at the address provided by the prison but did not receive a reply.

21. We informed HM Coroner for Teesside of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

22. One of the Ombudsman's family liaison officers contacted Mr Mason's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked about Mr Mason's mental healthcare.

Background Information

HMP Holme House

23. HMP Holme House is a medium security training prison holding over 1,200 men. G4S provided health services at the prison at the time of Mr Mason's death. There is a 24-hour healthcare unit with 16 beds.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Holme House was in February and March 2020, but the inspection report has not yet been published.

25. The previous inspection was in July 2017. Inspectors reported problems with drug availability, and a rise in violence since the previous inspection. The recent introduction of in-cell phones had helped prisoners maintain family contact. Most prisoners felt respected by staff, but relationships were often strained. Only 14% of prisoners said that staff spoke to them while they were on association and inspectors observed some distant supervision during association.

Independent Monitoring Board

26. 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 2018, the IMB reported that there had been significant and steady improvements in the stability and performance of the prison. There were staffing issues, and the maintenance of the fabric of the buildings needed attention.

Previous deaths at HMP Holme House

27. Mr Mason was the sixteenth Holme House prisoner to die since the beginning of 2017. Twelve of the previous deaths were from natural causes, one was drug-related, and one is awaiting classification. There have been four further deaths since Mr Mason's, three of which were due to natural causes and one was self-inflicted. In a previous report we made a recommendation about the importance of calling an ambulance immediately when a medical emergency code is called, a recommendation we repeat here.

Assessment, Care in Custody and Teamwork

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

29. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The

ACCT plan should not be closed until all the actions of the caremap have been completed.

Key Events

30. In June 2019, Mr Lee Mason was arrested and charged with an assault against his then-partner. Mr Mason's offence took place after he had been drinking. He said he had cut his partner's leg accidentally while he was using a knife to cut his own neck. He needed stitches to his wound.

31. Mr Mason was remanded in custody and arrived at HMP Durham on 27 June. He arrived at prison with a self-harm warning form that had been opened the previous day when he had made threats to hang himself. The form noted that he said he had no thoughts of suicide or self-harm that day.

32. Mr Mason had a number of previous convictions, many of which involved drugs and alcohol, and he had been in prison before. In the community, he had harmed himself in October 2018 after breaking up with his partner and was prescribed antidepressants. He was discharged from the care of the community mental health team the following month as he was not engaging with them.

33. In a reception induction interview, Mr Mason said that he had been in Durham before and had no issues with being there. He said that he had no thoughts of harming himself. At an initial health screen, Mr Mason told the nurse that he had cut himself after a row with his then-partner. He said that he had done it on an impulse, and it was the first time he had done so. It was agreed that he could keep his antibiotic medication in his own possession.

34. In a secondary health screen, Mr Mason said he had no problems with alcohol or drugs. He said that the recent cut to his neck was not a suicide attempt but just an impulse. The nurse noted that he was not in a low mood, had no thoughts of self-harm, was fully orientated and was displaying no signs of psychosis.

35. A worker from the Drug and Alcohol Recovery Team (DART) saw Mr Mason to discuss whether they could provide him with any support. Mr Mason did not want to engage with the team.

36. On 9 July, an officer introduced herself to Mr Mason as his key worker (first port of call for any issues or requests for assistance). Mr Mason told her that he was settled. He said he had no thoughts of self-harm and felt safe where he was.

37. On 10 July, healthcare staff removed Mr Mason's stitches. The wound had healed well, and he did not need any further treatment or medication.

38. The key worker went to see Mr Mason on 16 July, but he did not want to speak to her. She tried again on 26 July, but, again, he did not want to talk to her.

39. On 1 August, Mr Mason was convicted of malicious wounding and sentenced to 12 months imprisonment. Court reports referred to his previous self-harm due to relationship problems. Court staff completed a self-harm warning form again, referring to him having recently cut his neck. With this in mind, a prison officer on his wing asked Mr Mason how he was when he got back to prison. Mr Mason said that he was fine.

40. The key worker saw Mr Mason on 5 August. Mr Mason said that he was pleased that the length of his sentence meant that he would be able to apply for Home

Detention Curfew (release from prison under supervision to reside at a specific address) before Christmas. She noted that he had returned from court with a self-harm warning form, but Mr Mason said that he had already spoken to officers and he assured her that he had no thoughts of harming himself. He had been allocated to HMP Holme House and was pleased as this meant that his former partner, who continued to visit him, would be able to visit more easily. He asked her to arrange for his former partner's telephone number to be added to his list of allowed numbers, which she did.

HMP Holme House

41. On 7 August, Mr Mason moved to Holme House. The escort papers that accompanied him did not contain any self-harm warnings.

42. When he got to Holme House, Mr Mason told a nurse during a reception health screen that he had no physical or mental health issues. He said he had no thoughts of suicide or self-harm. He was again offered the opportunity to engage with the DART team but declined.

43. When Mr Mason passed through the body scanner it gave a positive reading, indicating that he may have secreted an object internally. The Duty Governor was informed, and he agreed that Mr Mason should spend a period in the segregation unit. A nurse completed a segregation health screen and noted on his record that he did not require any medical intervention. Staff checked on Mr Mason hourly until 9.00am on 8 August. No contraband had been found. Mr Mason was taken out of the segregation unit and back to reception.

44. An officer took Mr Mason through the reception process. Mr Mason denied having any thoughts of self-harm. He said that he was well-versed in prison rules and procedures. The officer provided him with induction information. This covered available support systems, including Listeners (prisoners trained by the Samaritans to provide peer support), access to the Samaritans, as well as support from prison staff. Mr Mason said that he did not have any issues he needed to address.

45. On 9 August, Mr Mason had a secondary health screen. He also submitted an application for Home Detention Curfew. He gave his father's address as his intended residence.

46. On 14 August, Mr Mason asked to speak to someone about having suffered from anxiety and depression before coming to prison. He was referred to the mental health team. On 15 August, a nurse assessed him and referred him to the Rethink team, who provide psychological therapy.

47. On 23 August, Mr Mason's former partner visited him.

48. On 28 August, an officer introduced herself to Mr Mason as his key worker. She gave him a progression plan to complete and said that they would go through it together at their next keywork session. Mr Mason said that he was settling in well and that he got on with his cellmate. In interview, she said that Mr Mason told her that he had separated from his former partner, but that she was still supportive and would continue to speak with him on the telephone. His former partner visited him on 4 September.

49. On 9 September, Mr Mason did not go to work, reporting that he was sick. His key worker went to see him in his cell. He said that he had vomited through the night. She asked if he had filled out his progression plan, but he said that he could not be bothered. He said that he had only started work in the kitchens two days previously but was enjoying it. He was starting to plan for his release and would either move in with his father or go to a hostel. He said that although they were no longer a couple, his former partner was still supportive. She noted that Mr Mason said that "he is not in the right frame of mind and this is causing issues between them as he self-harms". She recorded that she had asked if he was in touch with the mental health team, and he said he was. She explained how to get an appointment if he wanted one.

50. On 10 September, Mr Mason was told that his father's address had not been approved for HDC. He would still be eligible but would need to go to an Approved Premises (formerly known as probation or bail hostels). His offender manager would identify an appropriate placement.

51. On 24 September, his key worker went to see Mr Mason. She recorded that he had again reported sick. She recorded that Mr Mason appeared "distressed" and said that he had not gone to work as "he could not face being around anyone as he is feeling extremely down". He said this was due to a number of factors which were "all getting to him". He had recently separated from his partner and she had not visited him for three weeks. He had been told he could not have HDC at his father's address but would have to live in a hostel some distance from his family and where he had been hoping to work, which he now thought he would not be able to do. He blamed his former partner for this. He said that if he went to the hostel, he would be back in jail in a couple of weeks because of the curfew and being so far from family and work.

52. The key worker also recorded that Mr Mason said he had put in an application to see someone from the mental health team. He asked her if she would contact the kitchens and explain why he was not at work, so he did not lose the job. She did so and was told he would not be sacked if he was sick for a couple of days.

53. The key worker said in interview that she had no concerns that he would harm himself. Although he was feeling low at that time, he engaged well and was looking to the future, talking about going back to work the following week and discussing his release.

54. Over the following days, Mr Mason made a number of telephone calls to his former partner. The majority did not connect. The investigator listened to those which did, and while Mr Mason and his former partner had disagreements, they did not indicate that Mr Mason was in crisis.

55. On 27 September, Mr Mason was due to attend the healthcare centre for a mental health assessment. When he did not arrive, a psychological wellbeing practitioner went to see him. Prison officers told her that he was unwell, so she asked them to unlock him so she could ask if he wanted to undertake the assessment on the wing. Mr Mason told her that he did not feel up to taking the assessment that day but would still like to see the mental health team as he felt low. He asked if the appointment could be rescheduled. They agreed that she would put him back on the waiting list. Mr Mason told her that he had no thoughts of harming himself. He

said that his relationship with his father was a protective factor, and he was aware of the support available to him through staff, Listeners, and the Samaritans.

56. On 29 September, Mr Mason spoke to his former partner on the telephone. During the conversation he asked her when she was next going to visit him. She said that she would let him know when it was booked. He subsequently telephoned her a number of times, but the calls were not connected.

Events of 30 September 2019

57. At 8.00am on 30 September, staff unlocked prisoners who were going to work. Mr Mason was not due to work that morning, but his cellmate was, so an officer unlocked their cell and spoke to them both. In interview, she said that she did not notice anything out of the ordinary about Mr Mason during the exchange.

58. At 8.30am, Mr Mason's cellmate went to work, and at 8.50am prisoners remaining on the wing, including Mr Mason, were locked back in their cells. At 9.50am, there was a roll check. The prison has not identified who conducted the check on Mr Mason's wing that morning, but no concerns were raised.

59. At 11.30am, prisoners who had been to work were returning to their cells for lunch. Officer A was supervising the gate, and Officer B escorted Mr Mason's cellmate back to his cell. She unlocked the cell and saw Mr Mason hanging from the toilet door by a ligature made from a bed sheet. CCTV footage shows that this was at 11.34am.

60. Officer B called "Staff" for assistance and ushered the cellmate away. Officer A ran to the cell, and as he approached Officer B said to him "code blue", an emergency code meaning that a prisoner was not, or was having trouble, breathing. Within 20 seconds, Officer A was inside the cell. He supported Mr Mason's weight and used his anti-ligature knife to cut the ligature, then lowered Mr Mason to the floor. He had medical training and checked Mr Mason for signs of life. Unable to find any, he began to perform cardiopulmonary resuscitation (CPR, consisting of chest compressions and rescue breaths).

61. Other staff responded to the emergency call. An officer, who the prison has not been able to identify, called a code blue emergency over the radio and added that it was a hanging.

62. The orderly officer, a Custodial Manager (CM), arrived at the cell and radioed that an ambulance was required. The control room replied that they were on the telephone to the Ambulance Service at the time. The ambulance service records show that the prison's control room requested an ambulance at 11.39am.

63. A prison paramedic and a healthcare team support worker arrived at the cell and joined Officer A in providing medical aid. They applied a defibrillator (a machine that can, in some circumstances, restart the heart) but it advised them to continue with CPR. They were joined by Nurse A and continued to provide medical assistance until ambulance paramedics took over.

64. Mr Mason began to breathe but went into cardiac arrest and was given adrenalin. He was then transferred to an ambulance and taken to North Tees Hospital.

65. Mr Mason was unconscious and was taken to the intensive care unit. Prison staff opened ACCT procedures (Prison Service support for those at risk of self-harm). An escort risk assessment had been completed before Mr Mason had left the prison and he was not restrained.

66. Records show that medical staff from Holme House contacted the hospital on 1 and 3 October to discuss his condition. On 3 October, Mr Mason was officially released from prison on temporary licence.

67. On 4 October a member of Holme House's medical team discussed Mr Mason's care with the hospital. Scans showed that he had suffered a serious brain injury due to having been deprived of oxygen, and it was not thought that he would recover. Mr Mason remained unconscious until 7 October when, with the agreement of his family, life support was withdrawn. Mr Mason died at 2.18pm.

Contact with Mr Mason's family

68. When Mr Mason was taken to hospital, an officer was appointed family liaison officer. She and another officer travelled to Mr Mason's sister's address and informed her that Mr Mason had been taken to North Tees General Hospital. They remained in contact with Mr Mason's family while he was in hospital and after he died. In line with national guidance, Holme House offered a contribution to the costs of Mr Mason's funeral.

Support for prisoners and staff

69. After Mr Mason's death, one of the prison's senior managers 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. In interview, staff said that when news came through that Mr Mason had died, further support was offered.

70. 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

71. At the time of issuing the initial report of the investigation into Mr Mason's death, this office had not received the post-mortem report.

72. Due to the time Mr Mason spent receiving treatment in hospital, toxicology tests were not undertaken.

Findings

Assessment of risk

73. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 74/2011, Early Days In Custody, both list a number of risk factors and potential triggers for suicide and self-harm. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action.

74. Mr Mason had a number of these risks during his time in Holme House. He had a history of substance misuse, he had complained of low mood, he had recently self-harmed, he had been convicted of a violent offence against his partner, and his relationship had broken down.

75. Holme House has an early days' induction proforma that is used in reception, though it does not appear to have been used for Mr Mason. The standard proforma contains a question for prisoners about thoughts of self-harm, but reception procedures in Holme House do not explore any other risk factors.

76. During his time in Holme House, there were no indications that Mr Mason was having any difficulties within the prison. There is no evidence of bullying, debt, or isolation. Mr Mason told his key worker that he got on well with his cellmate, and he associated with other prisoners during hours allowed for socialising. There is no evidence of any conflict with any other prisoners.

77. Key workers should spend an average of 45 minutes per week on activities for each of their allocated prisoners, including having meaningful conversations. An officer was Mr Mason's key worker for just over four weeks and saw him three times for keywork sessions. The entries that she made on Mr Mason's record do indicate meaningful interactions.

78. The key worker was aware of Mr Mason's relationship difficulties, but when the investigator asked her about a note she had made about Mr Mason talking about self-harm, she said she could not remember this or what he had said. She was familiar with ACCT procedures and said that at no stage in her interactions with him did she have concerns that Mr Mason would harm himself.

79. The wing staff the investigator interviewed said that Mr Mason was not particularly talkative in dealings with them. However, there is no evidence of that wing staff had any engagement with Mr Mason. Mr Mason's electronic record contains only three entries (plus a management check) from 23 August until 30 September, all by his key worker. There are no entries at all in the last six days of his life after he told his key worker that he felt "extremely down".

80. In that last week up to 30 September, he made nearly 600 attempts to call his former partner. She said that this was not unusual, and she was not concerned. However, this could have indicated an element of crisis and, if it had been considered with other factors, may have led to closer scrutiny of the risk he presented to himself.

81. None of the staff who had contact with Mr Mason considered him to be at risk of suicide or self-harm, despite the range of his risk factors. When asked, Mr Mason said he had no thoughts of self-harm. However, while a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.

82. Mr Mason had a number of risk factors, and we would have preferred to have seen more evidence of recognition of these by staff who interacted with him. The lack of evidence of interaction makes it difficult to be confident that the risks were fully considered.

83. We also consider that Mr Mason's key worker should have paid more attention when Mr Mason mentioned self-harm in the context of his relationship breakdown on 9 September, and when he told her on 24 September that he was "extremely down" over his relationship and the significant change to his release plans. We are concerned that there is no evidence that she alerted wing staff to the way he was feeling or considered opening an ACCT. We do not say that an ACCT should necessarily have been opened, but we would have expected to see some recognition that it might be a possibility.

84. We make the following recommendations:

The Governor should ensure that prison staff are aware of the risk factors that might put prisoners at risk of suicide or self-harm and do not rely solely on how a prisoner behaves or what he says when assessing risk. This should include considering and recording the known risk factors of newly arrived prisoners.

The Governor should encourage and enable wing staff to engage regularly and positively with the prisoners in their care.

Mr Mason's healthcare

85. The clinical reviewer concluded that the healthcare Mr Mason received was equivalent to that which he could have expected in the community.

86. When he hanged himself, he was awaiting a mental health assessment, which had been scheduled for 1 October. The clinical reviewer said that this was within appropriate timescales, and he had been risk assessed on 27 September.

87. Mr Mason had previous convictions for drug-related offences. On arrival at Durham, he denied issues with drugs and was assessed as appropriate to hold his medication in his own possession. There were no intelligence reports that indicated any links between Mr Mason and the drug culture in prison. He was offered the chance to engage with substance misuse services but declined. There was no evidence of drug use found in his cell. There is nothing to indicate that substance misuse played a part in Mr Mason's death, and the clinical reviewer concluded that Mr Mason's substance misuse care was appropriate.

88. Despite alcohol playing a part in Mr Mason's offence, there is no evidence that he went through any detoxification programme or was screened for alcohol misuse. The clinical reviewer recommended that alcohol audits should be carried out.

89. Mr Mason was in hospital from 30 September until 8 October. His medical records indicate that healthcare staff at the prison contacted the hospital on three of those days. The clinical reviewer was content that while Mr Mason remained unconscious, this was sufficiently regular contact to monitor his condition.

Emergency response

90. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, contains a mandatory instruction that control room staff must call an ambulance immediately when a code blue or code red emergency is called.

91. When Officer B realised that Mr Mason was hanging, she called for staff assistance and when Officer A ran to assist she told him it was a code blue emergency. Officer B was not carrying a radio, and Officer A ran straight to help Mr Mason. The prison was unable to identify who called the code blue emergency over the radio.

92. When the emergency code was used, this should have prompted the control room to request an ambulance. The recordings of radio traffic that the prison provided to the investigator did not include time stamps, but some 40 radio messages after the code blue call, the orderly officer radioed that an ambulance was required. The control room replied that they were on the telephone to the Ambulance Service at the time. The telephone call between the prison and the Ambulance Service only lasted two minutes, and Ambulance Service records show that the call was made at 11.39am. CCTV footage showed that Officer B opened the cell door at 11.34am. While the prison has confirmed that there was inconsistency between the clocks used for each system, it is possible that there was an avoidable delay between the code blue call and the control room summoning an ambulance. We make the following recommendation:

The Governor should ensure that:

- **all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies; and**
- **the control room calls an ambulance immediately when an emergency code is used.**

93. Emergency response healthcare staff do not carry keys at Holme House. They are therefore reliant on prison staff to enable access to locked areas of the prison for them. In Mr Mason's case it does not seem to have caused a delay but may do so in future emergencies. We make the following recommendation:

The Governor and Head of Healthcare should ensure that arrangements for medical emergency responders do not cause delays in medical aid reaching prisoners in emergencies.

94. The clinical reviewer said that the efforts of the staff who provided medical aid to Mr Mason should be acknowledged. We recommend:

The Governor and Head of Healthcare should ensure that this report is shared with Officer A, the prison paramedic, the healthcare team support worker and Nurse A (who tried commendably to preserve Mr Mason's life) so they are aware of the Ombudsman's findings.

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Independent Investigations

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

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

T l 020 7633 4100