Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Mason, a prisoner at HMP Lancaster Farms, on 12 November 2020

A report by the Prisons and Probation Ombudsman

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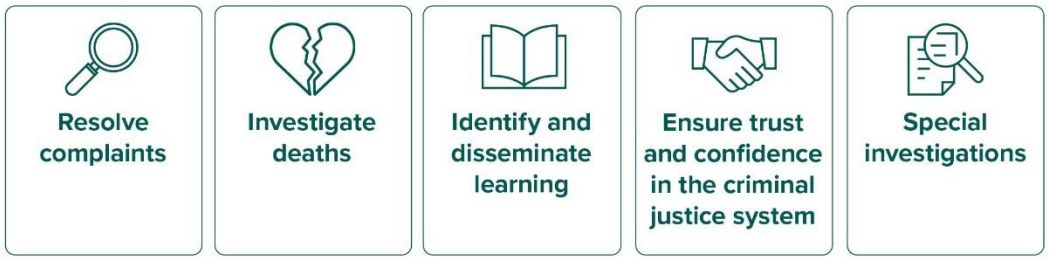
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Andrew Mason died in hospital of COVID-19 pneumonitis on 12 November 2020, while a prisoner at HMP Lancaster Farms. He had been admitted to hospital 18 days earlier. He was 63 years old. I offer my condolences to Mr Mason's family and friends.

The clinical reviewer concluded that the care Mr Mason received at Lancaster Farms was equivalent to that which he could have expected to receive in the community, though she found that healthcare staff should have created a COVID-19 care plan for Mr Mason when he became symptomatic.

I am concerned that prisoners may be hiding their COVID-19 symptoms to avoid isolating and that is putting themselves, other prisoners and members of staff at risk.

I am also concerned that when Mr Mason was taken to hospital, a senior prison manager authorised the use of double cuffs, despite Mr Mason being a very unwell category C prisoner. There was limited input from healthcare staff on Mr Mason's current condition and mobility, which meant that his risk of escape was not properly assessed. I do not consider that the use of restraints on Mr Mason was proportionate to the risk he posed.

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 2023**

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Summary

Events

1. In 2006, Mr Andrew Mason was sentenced to an indeterminate prison sentence, with a minimum time to serve of three years, for a violent offence. Mr Mason had been released from prison in 2018 but was recalled on 3 April 2020. On 28 April, Mr Mason was moved to HMP Lancaster Farms.

2. On 22 October, a nurse and a healthcare support worker saw Mr Mason, who said that he had started feeling unwell, with a high temperature and loss of smell. The nurse told Mr Mason to report any worsening of his symptoms immediately and arranged for healthcare staff to review him. The healthcare support worker swabbed Mr Mason for COVID-19 and he tested positive two days later.

3. At approximately 11.00am on 25 October, a nurse saw Mr Mason, who said that he felt very short of breath. The nurse found that Mr Mason's oxygen saturation rate was very low, so she called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing).

4. Between 11.18am and 12.20pm, the prison's control room made four calls to the ambulance service to request an ambulance and to chase it up as the nurses were concerned about Mr Mason's condition. An ambulance arrived at 12.27pm.

5. At 1.01pm, paramedics took Mr Mason to the Royal Lancaster Infirmary. Two prison officers accompanied Mr Mason and restrained him by 'double cuffing' him using an escort chain (when the prisoner's hands are handcuffed in front of him and an escort chain is attached – a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to a prison officer).

6. Shortly after he arrived, hospital doctors decided to ventilate Mr Mason. One of the escorting officers asked for permission to remove the restraints, but a senior prison manager refused this.

7. At 5.45pm, hospital doctors moved Mr Mason to the intensive care unit and placed him in a medically induced coma. The senior prison manager authorised the escorting officers to remove the restraints, which were not reapplied.

8. Mr Mason's condition continued to deteriorate, and he died at 5.56pm on 12 November.

9. A hospital doctor recorded that Mr Mason's death was caused by COVID-19 pneumonitis.

Findings

Clinical care

10. The clinical reviewer found that the care Mr Mason received for his COVID-19 symptoms was equivalent to that which he could have expected to receive in the community at that time. However, the clinical reviewer was concerned at the lack of a COVID-19 care plan or escalation plan for Mr Mason.

11. We are concerned that prisoners were believed to be hiding COVID-19 symptoms to avoid isolating.

12. We are also concerned that healthcare staff are unable to directly contact the ambulance service to provide updates on a prisoner's condition.

Restraints, security and escorts

13. We do not consider that the use of or level of restraints was justified when Mr Mason was taken to hospital given his poor health, mobility and category C status. We are concerned that a member of healthcare staff did not include information on Mr Mason's current condition on the escort risk assessment and that his risks to the public and of escape were overestimated, as a prison manager could not access his intelligence records. We are also concerned that escorting officers were placed at risk of catching COVID-19 when Mr Mason was ventilated.

Recommendations

- The Governor and the Head of Healthcare should educate prisoners about the risks of denying or hiding COVID-19 symptoms.
- The Head of Healthcare should ensure that there is a clear pathway or protocol for managing prisoners with suspected or known COVID-19.
- The Governor and the Head of Healthcare should ensure wherever possible that healthcare staff are able to talk directly to the local ambulance service if required.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:
    - healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape;
    - prison staff complete the security assessment section of the escort risk assessment by assessing the prisoner's intelligence file; and
    - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.
- The Governor should ensure that managers authorise the removal of restraints for COVID-19 positive, non-category A prisoners needing ventilation or intensive care unit treatment, in line with the Standard Operating Procedure, Escorts & Bedwatches – COVID-19, unless abnormal circumstances apply.

The Investigation Process

14. The PPO investigator issued notices to staff and prisoners at HMP Lancaster Farms informing them of the investigation and asking anyone with relevant information to contact him.

15. He obtained copies of relevant extracts from Mr Mason's prison and medical records.

16. NHS England commissioned an independent clinical reviewer to review Mr Mason's clinical care at the prison.

17. The investigator interviewed six members of staff at Lancaster Farms on 29 January and 19 February 2021. The interviews took place by video-link because of the COVID-19 restrictions in place.

18. We informed HM Coroner for Lancashire and Blackburn with Darwin of the investigation. He gave us the cause of death as determined by a hospital doctor. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Mason's sister, son and ex-wife to explain the investigation and to ask if they had any matters they wanted the investigation to consider. None of them responded to our letters.

20. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies but raised issues with some of the recommendations. We removed one recommendation and amended two others.

Background Information

HMP Lancaster Farms

21. HMP Lancaster Farms is a modern, medium security resettlement prison with accommodation for 560 adult male prisoners. Spectrum Community Health CIC provides primary care and substance misuse services, and Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services. Healthcare staff work from 7.30am to 7.30pm, Monday to Thursday, 7.30am to 6.00pm on Friday and 8.00am to 5.30pm at weekends.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Lancaster Farms was in October and November 2018. Inspectors reported that the provision of healthcare was improving and satisfactory, though treatment for long-term conditions was underdeveloped and prisoners often waited too long to see the GP. They also found that the healthcare team was well-managed, despite ongoing recruitment issues that impacted the skill mix among nurses.

23. Inspectors also found that the decisions to handcuff prisoners for external escorts were based on individual risk assessments, which were completed adequately, and the use of restraints was usually considered and proportionate.

Independent Monitoring Board

24. 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 January 2020, the IMB reported the ageing population at the prison placed additional demand on staff and healthcare resources. They also found that waiting times to see the GP were less than two weeks, though prisoners faced difficulties moving between wings and the healthcare centre, which caused some to miss their appointments.

Previous deaths at HMP Lancaster Farms

25. Mr Mason was the fourth prisoner to die at Lancaster Farms since November 2018. One of the previous deaths was from natural causes, one was self-inflicted, and in one, the cause was unascertained. We have made a previous recommendation about the need to pass concise information to the ambulance service.

26. There have been no other COVID-19 related deaths at Lancaster Farms.

Coronavirus (COVID-19)

27. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

28. COVID-19 can make anyone seriously ill, but the risk is higher for some people. There are two levels of higher risk: high-risk (clinically extremely vulnerable) and moderate risk (clinically vulnerable). People at high risk include those who have had an organ transplant; have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

29. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

30. On 13 March, PHE's National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread.

31. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime, and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and offered the opportunity to be located in protective isolation.

32. On 31 March HMPPS, in consultation with PHE, issued an order to significantly reduce transfers between prisons. Other measures, known as 'compartmentalisation' were also announced. These measures were designed to be implemented at local level, depending on the needs of each individual establishment, and included:

    - Protective Isolation Units (PIUs): to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation.
    - Shielding Units (SUs): to protect the most vulnerable identified through collaboration with NHS England, with enhanced levels of bio-security including dedicated staff;
    - Reverse Cohorting Units (RCUs): to accommodate new receptions or transfers in for a period of 14 days to detect any emergent infectious cases before entering general population. These units could also accommodate any one returning from hospital.

Key Events

33. On 3 March 2006, Mr Andrew Mason was sentenced to an indeterminate prison sentence, with a minimum time to serve of three years, for a violent offence. Mr Mason was released from prison on 12 July 2018, but recalled on 25 August, and then released again on 25 November 2019, but recalled on 3 April 2020. On 28 April, Mr Mason was moved to HMP Lancaster Farms.

34. Throughout his time at Lancaster Farms, Mr Mason did not require any intervention from primary healthcare, except for a review by a prison GP for shoulder pain in July 2020.

35. On 22 October, a nurse and a healthcare support worker saw Mr Mason, who said that he had started feeling unwell, with a high temperature and loss of smell. The nurse noted that Mr Mason appeared pale, but he said he did not have shortness of breath. The nurse told Mr Mason to report any worsening of his symptoms immediately and arranged for healthcare staff to review him the following day. She also noted that Mr Mason had paracetamol in his possession. The healthcare support worker swabbed Mr Mason for COVID-19.

36. From that point, Mr Mason, and three other prisoners, began isolating, though a wing observation book entry said, “There is talk amongst the lads that they are not declaring symptoms of COVID as they do not want to isolate for 10 days.”

37. The following day, a nurse saw Mr Mason, who said he felt unwell, was achy and had a headache. The nurse noted that Mr Mason had pain relief in possession and told him to report any changes to prison staff.

38. On 24 October, a nurse saw Mr Mason, who said that he felt slightly better. The nurse told Mr Mason to report any worsening of his symptoms.

39. Later that day, a nurse reviewed Mr Mason’s swab result and noted that he had tested positive for COVID-19.

40. At approximately 11.00am on 25 October, a nurse saw Mr Mason, who said that he felt very short of breath. The nurse took Mr Mason’s basic observations and found that his temperature was high and his oxygen saturation rate was very low at 77% (a normal oxygen saturation is 96 to 100%). At 11.18am, the nurse called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) and gave him 15 litres of oxygen, which raised his oxygen saturation rate to between 90% and 92%.

41. At 11.18am, the prison’s control room called for an ambulance. This was followed by three further calls, between 11.45am and 12.20pm, as the nurses were concerned about Mr Mason’s condition. During each call, the prison’s control room passed on limited information from the nurses to the ambulance service operator. An ambulance arrived at 12.27pm.

42. At 1.01pm, paramedics took Mr Mason to the Royal Lancaster Infirmary. Mr Mason used a wheelchair to move from his cell to the ambulance. Two prison officers accompanied Mr Mason and restrained him with double cuffs (double cuffing is when the prisoner’s hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs), though, as he was COVID-19

positive, they used an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) rather than an additional set of handcuffs.

43. Shortly after he arrived at hospital, hospital doctors decided to ventilate Mr Mason. A hospital doctor told one of the escorting officers that this treatment would be an aerosol generating procedure (AGP – a medical procedure that can result in the release of airborne particles from the respiratory tract of someone with COVID-19). The officer contacted the prison and asked for permission to remove the restraints but a senior prison manager refused this.

44. At 5.45pm, hospital doctors moved Mr Mason to the intensive care unit and placed him in a medically induced coma. The senior manager authorised the escorting officers to remove the restraints, which were not reapplied.

45. Mr Mason's condition continued to deteriorate, and he died at 5.56pm on 12 November.

Contact with Mr Mason's family

46. At approximately 1.45pm on 25 October, hospital staff asked Mr Mason for contact details for his next of kin, but he said that he did not have any next of kin and did not want anybody to know that he was in hospital.

47. At 2.25pm on 12 November, a hospital sister contacted the prison and asked for contact details for Mr Mason's next of kin as they wanted to discuss withdrawing treatment for him. On Mr Mason's electronic prison record (known as NOMIS), he had previously named his ex-wife, sister and son as his next of kin. The prison tried to contact them but their contact details were not active. A senior prison manager asked Wiltshire Police to visit each of Mr Mason's next of kin.

48. At 5.20pm, the senior prison manager telephoned Mr Mason's sister and told her that her brother was seriously ill in hospital. She agreed to take on the next of kin responsibilities, so the prison passed her contact details to the hospital.

49. At 7.05pm, the senior prison manager telephoned Mr Mason's sister to break the news of his death and to offer her condolences and support.

50. On 13 November, the Governor telephoned Mr Mason's sister to offer his condolences. Mr Mason's sister asked questions about the arrangements for Mr Mason and the Governor explained that the prison had appointed a family liaison officer (FLO), who would answer her questions on 16 November.

51. On 17 November, the FLO telephoned Mr Mason's sister, who said that she had contacted Mr Mason's son. The FLO said that Mr Mason's ex-wife had contacted HMP Kirkham about his death but that he would not speak to her without the sister's permission. Mr Mason's sister decided that she did not want his ex-wife to be involved so no one from the prison had any contact with her.

52. The FLO continued to support Mr Mason's sister until his funeral, which was held on 16 December 2020. The prison contributed towards the costs of the funeral in line with national instructions.

Support for prisoners and staff

53. The FLO, who was at the hospital when Mr Mason died, was debriefed and offered the support of the prison's care team.

54. 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.

Cause of death

55. The coroner accepted the cause of death provided by the hospital and no post-mortem examination was carried out. A hospital doctor recorded that Mr Mason's death was caused by COVID-19 pneumonitis.

Findings

Clinical care

Management of Mr Mason's risk of infection from COVID-19

56. As Mr Mason had not left Lancaster Farms before he became unwell, it would appear that he contracted COVID-19 in prison. We note that in the days before Mr Mason became unwell, other prisoners on the wing had tested positive for COVID-19 and they had been isolated along with other prisoners they had been in close contact with.

57. Mr Mason had had limited contact with primary care healthcare staff while at Lancaster Farms before this. According to the Public Health England and Department of Health and Social Care guidance for COVID-19, Mr Mason had no health issues that required him to shield and he was not defined as being at risk of COVID-19.

58. We are satisfied that healthcare staff appropriately managed Mr Mason's risk of infection from COVID-19, as they promptly swabbed and isolated any prisoner who said they had symptoms. However, we note that on 22 October, despite Mr Mason and three other prisoners being isolated, there was a belief that other prisoners were hiding their symptoms to avoid this isolation. Clearly this action put prisoners and staff at risk. We make the following recommendation:

    The Governor and the Head of Healthcare should educate prisoners about the risks of denying or hiding COVID-19 symptoms.

Mr Mason's COVID-19 symptoms

59. Mr Mason had a high temperature and loss of smell from 22 October. The clinical reviewer was satisfied that these were minor symptoms, so it was reasonable for healthcare staff to ask Mr Mason to isolate and take paracetamol without the need to check his clinical observations. Overall, the clinical reviewer was satisfied that the care Mr Mason received for his COVID-19 symptoms was satisfactory and equivalent to that which he could have expected to receive in the community at that time.

60. However, the clinical reviewer was concerned at the lack of a COVID-19 care plan or escalation plan for Mr Mason. A care plan would have allowed healthcare staff to maintain a standardised approach when seeing Mr Mason, including recording and discussing the concerning symptoms that he should look out for, when to take clinical observations if his condition deteriorated and when to escalate his care to the prison GP or for urgent hospital admission. We make the following recommendation:

    The Head of Healthcare should ensure that there is a clear pathway or protocol for managing prisoners with suspected or known COVID-19.

Calling for an ambulance

61. On 25 October, a nurse wanted to send Mr Mason to hospital urgently, yet it took over an hour for an ambulance to arrive. We are concerned that the control room operators were unable to concisely pass on the detailed medical information about Mr Mason's condition to the ambulance service and that healthcare staff were unable to contact the ambulance service directly to do this. We make the following recommendation:

    The Governor and the Head of Healthcare should ensure wherever possible that healthcare staff are able to talk directly to the local ambulance service if required.

Restraints, security and escorts

62. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

63. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

64. Prison Service Instruction 33/2015, External Prisoner Movement, defines the policy and guidance for the external escort of prisoners. It says that the normal practice is for category B and E-List prisoners to be double cuffed while on an escort and all other prisoners should be single cuffed unless the individual's risk assessment indicates that double cuffs are required. It also says that restraints will not normally be used when a prisoner's medical condition, advanced age or physical impairment renders restraints inappropriate.

65. When the nurse decided to send Mr Mason to hospital, he was acutely unwell with a very low oxygen saturation rate. A witness statement from a prison manager noted that Mr Mason needed to use a wheelchair when he moved from his cell to the ambulance. Despite Mr Mason's poor condition and limited mobility, the medical information section of the escort risk assessment made no reference to these issues.

66. When the manager assessed Mr Mason's risks, he decided that he presented a medium risk to the public, to hospital staff, of hostage taking and of escape. The manager also wrote that he had "no access to Mercury file" (Mercury is the name given to the prison's intelligence system). Mr Mason's intelligence file contained five intelligence reports, dated between May 2014 and June 2019, and only one contained any worrisome intelligence (two related to other prisoners, one was about a visitor and one was about the death of a family member).

67. We are concerned that Mr Mason's escort risk assessment was authorised without access to his Mercury file and that this resulted in an overestimation of the risks that he presented. Furthermore, we do not consider that it was appropriate to use double handcuffs on Mr Mason when he was taken to hospital. Double cuffing is usually required for moving category A or category B prisoners in good health. Mr Mason was a seriously ill, category C prisoner, with very poor mobility, and it is difficult to see how the escort risk assessment could conclude that he had the ability to escape unaided from two escort officers. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape;**
- **prison staff complete the security assessment section of the escort risk assessment by assessing the prisoner's intelligence file; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

68. A Standard Operating Procedure, Escorting & Bedwatches – COVID-19, sets out the procedure for escorting prisoners to hospital for treatment. It says that in normal circumstances where a category B, C or D prisoner needs to be ventilated or receive treatment from a hospital's intensive care unit, staff will remain outside the unit and observe the prisoner through an observation window.

69. After Mr Mason arrived in hospital, hospital doctors ventilated him, but a senior prison manager initially refused permission for the escorting officers to remove the restraints. This placed them at risk of catching COVID-19 and both had to isolate after being in hospital with Mr Mason. We are concerned that the Standard Operating Procedure was ignored, as there is nothing to suggest that there were unusual circumstances surrounding Mr Mason's treatment. We make the following recommendation:

The Governor should ensure that managers authorise the removal of restraints for COVID-19 positive, non-category A prisoners needing ventilation or intensive care unit treatment, in line with the Standard Operating Procedure, Escorts & Bedwatches – COVID-19, unless abnormal circumstances apply.

Liaison with Mr Mason's next of kin

70. Prison Rule 22 says that when a prisoner dies, the governor should "at once inform the prisoner's spouse or next of kin". This is reflected in PSI 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which requires prisons to contact the next of kin of prisoners who die. This PSI states that prisoners may chose more than one next of kin, which can include "chosen" as well as biological members.

71. Mr Mason had named his sister, son and ex-wife as his next of kin but the prison dealt solely with Mr Mason's sister, despite his ex-wife having contacted Kirkham to ask about him. We are concerned this decision ignored Mr Mason's wishes. We bring this to the Governor's attention.

Inquest

72. The inquest, held on 24 to 25 January 2022, concluded that Mr Mason's death was from natural causes.

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