Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Ferguson a prisoner at HMP Manchester on 25 September 2018

A report by the Prisons and Probation Ombudsman

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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*

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.

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

Mr Stephen Ferguson was found hanged in his cell at HMP Manchester on 25 September 2018. He was 33 years old. I offer my condolences to Mr Ferguson's family and friends.

The day before he was found hanged, Mr Ferguson had been sentenced to 14 years in prison, which was longer than he expected. The investigation found that on his return to prison after sentencing, staff failed to assess his risk of suicide and self-harm as they should have done. Healthcare staff should also have assessed him given his change in custodial status, but they failed to do so. We consider that an opportunity to support Mr Ferguson using Prison Service suicide and self-harm prevention procedures was missed.

Staff did not call the correct medical emergency code when they found Mr Ferguson. It made no difference in this case as Mr Ferguson was already dead, but I am concerned that yet again, our investigation has found that staff at Manchester are not following the prison's medical emergency protocol. This needs to be addressed.

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 **May 2019**

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Summary

Events

1. Mr Stephen Ferguson was remanded in prison custody on 15 December 2017, charged with a serious sexual offence, and sent to HMP Manchester.

2. Mr Ferguson was found guilty in June 2018 and was returned to Manchester to await sentencing. On 24 September, he was sentenced to 14 years imprisonment and five years on licence. Neither Mr Ferguson nor his family expected such a long sentence.

3. During the early hours of 25 September, an officer went to check on Mr Ferguson as he knew he had received a long sentence the day before. He was unable to see Mr Ferguson in his cell or get a response, so he called for staff assistance. A few minutes later other staff arrived and, when they entered Mr Ferguson's cell, they found him hanging in the toilet area. It was clear that Mr Ferguson had died, so staff did not attempt to resuscitate him. He was pronounced dead at 3.37am.

Findings

4. Mr Ferguson should have been screened to assess his risk of suicide and self-harm when he returned from court on 24 September but there is no evidence this was done. He should also have been assessed by healthcare staff as his custodial status had changed from unsentenced to sentenced, but again, this was not done. We consider that reception staff should have identified Mr Ferguson's increased risk of suicide and self-harm and considered starting suicide and self-harm procedures.

5. Staff used an old medical emergency code when they found Mr Ferguson, which resulted in a delay in calling an ambulance. Although it made no difference in this case because Mr Ferguson was dead when discovered, staff at Manchester need to be reminded to use the correct codes.

6. No hot debrief was held after the incident.

7. The clinical reviewer found that mental health staff did not use the standard assessment tools when assessing Mr Ferguson's mental health.

Recommendations

- The Governor and Head of Healthcare should ensure that prisoners passing through reception on return to the prison following a court appearance are screened to assess their risk of suicide and self-harm and for potential health problems.

- The Governor and Head of Healthcare should ensure that prisoners are assessed by healthcare staff when there has been a change in their custodial status.

- The Governor and Head of Healthcare should ensure reception staff assess a prisoner's risk of suicide and self-harm based on all known risk factors rather than a prisoner's presentation.
- The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.
- The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, and that all those involved in the incident are invited to attend.
- The Head of Healthcare should ensure the mental health team use the PHQ9 and GA7 tools for all prisoner referrals and assessments.

The Investigation Process

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

9. The investigator visited Manchester on 2 October 2018. She obtained copies of relevant extracts from Mr Ferguson's prison and medical records.

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

11. They interviewed 11 members of staff at Manchester on 31 October and 1 November.

12. We informed HM Coroner for Manchester of the investigation. The coroner gave us the preliminary cause of death. We have sent the coroner a copy of this report.

13. The investigator contacted Mr Ferguson's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked for the investigation to look at her son's mental health care, and we have addressed that in this report.

14. We shared our initial report with the Prison Service. They did not find any factual inaccuracies and their action plan is annexed to this report.

15. We provided a copy of our initial report to Mr Ferguson's mother. She raised a number of issues that mostly did not impact on the factual accuracy of the report. We have written to her separately. One issue she raised was that the prison had not contributed to Mr Ferguson's funeral. The prison has now taken steps to rectify this.

Background Information

HMP Manchester

16. HMP Manchester operates as both a high security prison and a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester Mental Health and Social Care Trust provides 24-hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Manchester was in June and July 2018. Inspectors noted there had been eight self-inflicted deaths since November 2014, three of which had occurred in the previous six months. The prison was responding well to the recommendations from the Prisons and Probation Ombudsman and a designated safer custody officer maintained a database to track the implementation of agreed actions. However, some actions had yet to be implemented and quality assurance was needed at a senior level to ensure that improvements were sustained.

Independent Monitoring Board

18. 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 28 February 2018, the IMB reported that they remained concerned about staff shortages and the effect on the prison's regime. The IMB expressed concern about the volatile atmosphere, poor prisoner behaviour and access to psychoactive substances on B Wing.

Previous deaths at HMP Manchester

19. Mr Ferguson was the 20th prisoner to die at Manchester since June 2015. Of the previous deaths, eight were self-inflicted, ten were from natural causes and one was unascertained. There have been three deaths since, one self-inflicted, one from natural causes and one awaiting classification.

20. We have repeatedly raised concerns about staff not following the prison's emergency response procedures. It is disappointing that we have to repeat that recommendation in this report. We have also previously identified concerns in reception procedures and staff's assessment of risk of suicide and self-harm. We have also identified the failure to hold a hot debrief in previous investigations.

Assessment, Care in Custody and Teamwork

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of an ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held. As part of the process a caremap (a 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. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

22. Mr Stephen Ferguson was remanded in prison custody on 15 December 2017, charged with a serious sexual offence against his partner, and sent to HMP Manchester. This was his first time in prison.

23. A healthcare assistant, assessed Mr Ferguson in reception. Mr Ferguson said he was on antidepressants but had no thoughts of suicide or self-harm. A doctor prescribed Mr Ferguson mirtazapine (an antidepressant) that evening.

24. Mr Ferguson's sister left a message on a Sharing Concerns Helpline on 20 December, because she was worried about her brother's mental health. This information was emailed to the mental health team, but no records have been retained to show what, if any, action was taken.

25. On 26 December, Mr Ferguson asked to see a member of the mental health team, for 'help for previous conditions'. A nurse asked Mr Ferguson to provide more detail. There is no record on SystmOne (electronic medical record) that he did so.

26. On 18 January 2018, Mr Ferguson booked himself onto a drugs and alcohol rehabilitation course. On 29 January, he was allocated a key worker, but he did not attend his first appointment on 1 February.

27. On 24 January, Mr Ferguson saw, a prison GP. They discussed Mr Ferguson's low mood, anger and anxiety, which he felt had got worse in prison. He suspected his cellmate had been stealing from him. He referred Mr Ferguson to the chaplaincy for counselling, and said he would speak to the security department about his cellmate. There is no evidence he did so. The prison GP changed Mr Ferguson's antidepressant from mirtazapine to sertraline.

28. On 25 January, Mr Ferguson submitted another application to speak to a member of the mental health team. A nurse replied that he was not under the care of the mental health team, that he had seen a doctor on 24 January, and he had a follow up appointment on 23 February. Mr Ferguson did not see a doctor on 23 February (he missed his appointment; no reason was noted) but met with his substance abuse key worker. They discussed his alcohol consumption which he felt was problematic and he asked to meet a volunteer from Alcoholics Anonymous (AA). This was not possible as the volunteer had stopped visiting the prison. No other action was taken. Mr Ferguson missed other meetings with his substance abuse key worker, but saw him again on 1 May. Mr Ferguson said he had a court date soon, and would rather discuss things again afterwards.

29. Mr Ferguson attended his trial from 4 June until 14 June. A nurse saw him before he left for court on each occasion, but not on his return. On 14 June, Mr Ferguson was found guilty and returned to Manchester to await sentencing. There is no record anyone spoke to Mr Ferguson on his return to the prison on 14 June.

30. Mr Ferguson submitted a third application to speak to a member of the mental health team on 20 August. He said that he was becoming aggressive and violent

and needed advice on how to curb this. Mr Ferguson was told he was on the mental health team's waiting list for assessment.

31. On 22 August, a nurse asked a Supervising Officer (SO) to assess Mr Ferguson's welfare on the wing and report back. The SO said that Mr Ferguson was feeling increasingly anxious and experienced thoughts of violence against other people, although he had no thoughts of self-harm. The mental health team added Mr Ferguson to their waiting list with a view to seeing him within two weeks.

32. A mental health nurse met with Mr Ferguson on 6 September. She noted he was in a single cell and seemed mentally stable. Mr Ferguson asked for help to manage his anger issues as he believed that this had contributed to his offence. She noted he was to remain under the care of a doctor at the prison and that he was not at risk of self-harm. She discussed Mr Ferguson at a mental health team meeting the next day. The meeting noted that he seemed settled in a single cell, this was his first time in prison, and he was concerned about his daughter who had been taken into care. They agreed that Mr Ferguson had no significant mental health issues and should remain under the care of a doctor to review his antidepressants. It was agreed that Mr Ferguson was not a risk to himself or to others.

33. A prison GP saw Mr Ferguson on 17 September. Mr Ferguson said he felt anxious and depressed (although not suicidal) and his prescription for sertraline was increased from 50mg to 100mg.

34. Mr Ferguson telephoned his mother during the evening of 21 September, three days before his court appearance for sentencing. Mr Ferguson said he was having difficulty contacting his daughter. He added that if he was not able to speak to her he would hang himself, but then Mr Ferguson laughed and said it was his daughter who kept him going.

35. Mr Ferguson made another application to speak to a member of the mental health team on 23 September, explaining that he was not sleeping, had nightmares and violent thoughts, and was worried he would act on them. Mr Ferguson did not say if these thoughts were towards other people or himself. He did not see anyone from the mental health team before he died.

Events of 24 and 25 September 2018

36. Mr Ferguson attended court on 24 September. His Person Escort Record (PER) noted Mr Ferguson was violent, a risk to staff and women, had been convicted of a sex offence and had been offered and refused vulnerable prisoner status. At court, Mr Ferguson was sentenced to 14 years imprisonment and five years on licence after release.

37. A SO saw Mr Ferguson when he returned to the prison from court at 4.55pm. An officer completed a Change of Status form for Mr Ferguson, which reflected that he had been newly sentenced, and put the form on the nurse's workstation in reception. (The form alerts staff to any changes that might affect a prisoner and in Mr Ferguson's case it was the length of sentence.)

38. A SO was aware Mr Ferguson had received a long sentence, asked him how he was feeling and whether he felt he needed a move to the Vulnerable Prisoner (VP) wing due to the nature of his offence. Mr Ferguson replied that he was 'fine' and wanted to return to B Wing. The SO said Mr Ferguson waited in a holding area (although it is not clear why). The nurse on duty was unaware that Mr Ferguson was there or needed to be seen (as he had been sentenced). The SO said Mr Ferguson's Change of Status form was left in a pile of papers for the nurse on their workstation in reception, but said that prisoners who return from court are not routinely seen by a member of the healthcare department. The nurse in reception did not see Mr Ferguson's Change of Status form or assess him.

39. Later that afternoon, the SO telephoned B Wing and told another SO that Mr Ferguson had received a substantial sentence and might need protection because of his offence. Mr Ferguson then returned to the same cell he had lived in for several months. There are no safer cells on the wing (a safer cell should have no obvious ligature points) and Mr Ferguson's cell had a handrail installed by the toilet, probably because an elderly or disabled prisoner had lived in the cell previously.

40. A SO saw Mr Ferguson return to B Wing and speak to some friends. Mr Ferguson then went into the wing office where he told the SO he had been sentenced to 19 years and intended to appeal against the length of sentence. The SO asked if he was going to be okay that night and Mr Ferguson said he would be fine, had no issues, needed to come to terms with what had happened at court and would appeal his sentence. The SO told the investigator that he considered their conversation indicated Mr Ferguson was thinking about the future, so he did not ask him whether he felt suicidal or intended to self-harm.

41. At 5.26pm, Mr Ferguson telephoned his mother's number, although it is not clear if he spoke to her or someone else. They spoke about the harshness of his sentence and the woman said she thought he would have received a maximum of two years imprisonment. Mr Ferguson asked that she stay in touch with his daughter, and the woman replied that he should not do anything to harm himself. Mr Ferguson said he would not.

42. Half an hour later, Mr Ferguson telephoned the same number and spoke to his mother. They discussed his sentence and appeal. Both sounded tearful and distraught. Mr Ferguson's mother said he must try to get through the night and Mr Ferguson replied that he had a baby girl to keep him going. He added that whatever happened, his mother should keep in contact with his daughter. Mr Ferguson said he would try to speak to a psychologist the next day as he had a habit of bottling things up. They also spoke about a visit he had booked for 26 September.

43. Mr Ferguson's last telephone call was to his father at 6.38pm. They expressed upset and shock about his sentence and spoke about an appeal. Mr Ferguson told his father he would contact his solicitor the next day and telephone his father again.

44. At approximately 3.00am on the morning of 25 September, an officer was checking all cell doors on B Wing. The officer decided to check on Mr Ferguson

as he was aware he had attended court the day before and had received a substantial sentence. The officer could see Mr Ferguson's television was on and he appeared to be in a bottom bunk bed, although the officer could not see whether he was breathing or detect any movement. The officer called his name and rattled the door, but received no response, so he telephoned Oscar 1 (the orderly officer in charge of the prison that night) for assistance, because he felt uneasy.

45. A Custodial Manager (CM) and another officer responded to the call and arrived at the cell at 3.07am. They went into Mr Ferguson's cell, pulled back the bedsheet and saw the bed was empty, except for a bundled-up sheet, made to look like a body in the bed. They looked towards the toilet area in the cell, and saw Mr Ferguson was suspended by a ligature from a handrail next to the toilet. The CM cut the ligature and laid Mr Ferguson on the floor. At 3.08am, the CM radioed a priority one call (a medical emergency code that was used at Manchester before February 2017, when it was replaced by a code blue).

46. Two nurses responded to the emergency call and attended the wing with their emergency equipment. They noted a deep ligature mark around Mr Ferguson's neck, he was cold, his pupils were fixed and dilated, he was not breathing and there was evidence of pooling of blood. The decision was made not to attempt cardiopulmonary resuscitation (CPR) as Mr Ferguson had clearly died.

47. Prison records show that they called an ambulance at 3.22am. When paramedics arrived, they agreed that CPR would not be appropriate and at 3.37am, recorded Mr Ferguson's death.

48. Mr Ferguson left two notes in his cell. One was to his daughter and the other to his mother and family. Mr Ferguson apologised for his actions (taking his life), and said he had not committed the offence he had been convicted of and could not cope with being away from his family for so many years.

Contact with Mr Ferguson's family

49. The prison chaplain and an officer visited Mr Ferguson's mother in person at 7.40am on 25 September, to break the news of his death. The prison is in the process of contributing to Mr Ferguson's funeral, in line with national guidance. There had initially been a problem paying an invoice from the funeral director.

Support for prisoners and staff

50. Staff involved in the emergency response said they were offered support by the prison's care team and felt supported by managers and other colleagues. However, we found no evidence that a debrief took place immediately after the incident.

51. The prison posted notices informing other prisoners of Mr Ferguson'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 Ferguson's death.

Post-mortem report

52. Mr Ferguson's post-mortem and toxicology reports were not available at the time of issuing this report, but a preliminary post-mortem report gave his cause of death as hanging.

Findings

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

53. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm from self, from others and to others (Safer Custody)*, lists a number of risk factors and potential triggers for suicide. A number applied to Mr Ferguson including that he had committed a violent offence against a family member, he had received a longer sentence than expected, and his relationship had broken down.

54. Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events such as attending court, sentencing at court, or being questioned by police, are factors that might have a significant impact on the health of the prisoner. For those prisoners passing through reception, prisons are required to have protocols in place for screening them to identify any potential healthcare or suicide and self-harm issues. PSI 07/2015, *Early Days in Custody*, says that the PER and any other available information must be examined by reception staff and the prisoner must be interviewed to assess their risk of suicide and self-harm. It also says that prisoners should be medically assessed where they return to the prison after a temporary absence with a change of status (such as from remand to convicted or unsentenced to sentenced).

55. Mr Ferguson appeared at court on 24 September, and was sentenced to 14 years imprisonment and a further five years on licence. A SO spoke to Mr Ferguson on his return to the prison but there is no evidence he assessed Mr Ferguson's risk of suicide or self-harm.

56. An officer completed a Change of Status form in reception, noting that Mr Ferguson had been sentenced. The form was left on the nurse's workstation but A nurse said she did not see it. She told the investigator if she had been aware of it, she would have assessed Mr Ferguson. All prisoners passing through reception at Manchester with a Change of Status form should be assessed by healthcare staff. Mr Ferguson was moved through reception and then back to the wing without being seen by a nurse. A SO said there was no system in place to check whether a prisoner had seen a member of healthcare staff, and nobody asked Mr Ferguson if he had done so.

57. We make the following recommendations:

    The Governor and Head of Healthcare should ensure that prisoners passing through reception on return to the prison following a court appearance are screened to assess their risk of suicide and self-harm and for potential health problems.

    The Governor and Head of Healthcare should ensure that prisoners are assessed by healthcare staff when there has been a change in their custodial status.

58. A SO told the investigator that he asked Mr Ferguson how he was feeling when he returned to the prison on 24 September and he said, "fine", so he did not consider starting ACCT procedures. A prisoner's presentation can reveal

something of their level of risk. However, it is only a reflection of their state of mind at the time a member of staff sees them, and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that too often staff place too much weight on their perception of a prisoner and do not consider all the relevant information.

59. Mr Ferguson already had a number of risk factors for suicide and self-harm, and then, on 24 September, he returned from court with a longer sentence than expected. We consider that staff should have recognised Mr Ferguson's increased risk and begun ACCT procedures. We make the following recommendation:

The Governor and Head of Healthcare should ensure reception staff assess a prisoner's risk of suicide and self-harm based on all known risk factors rather than a prisoner's presentation.

Emergency response

60. A CM radioed a priority one call when he found Mr Ferguson. This was a medical emergency code at Manchester before February 2017, when it was replaced by a code blue. (On 21 February 2017, the Governor issued a new order (reissued in November 2017 and 25 September 2018) instructing staff to use a code blue or red, in emergency situations.) The use of the wrong code delayed the calling of an ambulance. Although it made no difference in this case as Mr Ferguson was dead when found, staff need to be reminded to use the correct medical emergency codes. This is a recurring issue at Manchester. We found that the correct medical emergency code was not called in two of the three investigations into deaths at Manchester during 2018 that involved a medical emergency (The correct code was, however, called in a death that occurred in January 2019.) We make the following recommendation:

The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.

Staff support

61. PSI 64/2011 says, "In line with PSI 08/2010 *Post Incident Care*, a Hot Debrief must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited." We found no evidence that a hot debrief was held immediately after Mr Ferguson's death. We therefore repeat a recommendation made in a previous investigation:

The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, and that all those involved in the incident are invited to attend.

Mental health care

62. The clinical reviewer noted that Mr Ferguson had a history of anxiety and depression and that Manchester's mental health team were involved in his care. The clinical reviewer noted that when mental health staff assessed Mr Ferguson, they did not use a PHQ9 (patient health questionnaire) or GAD 7 (generalised anxiety disorder) which are standard assessment tools used in the community for anxiety and depression. We endorse the clinical reviewer's recommendation:

The Head of Healthcare should ensure the mental health team use the PHQ9 and GA7 tools for all prisoner referrals and assessments.

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