Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Ferguson, a prisoner at HMP Garth, on 9 December 2020

A report by the Prisons and Probation Ombudsman

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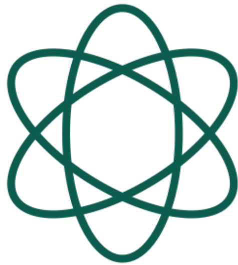
Our vision

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

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Summary

1. 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.

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

3. Mr Trevor Ferguson died in hospital on 9 December 2020, from COVID-19 pneumonia, while a prisoner at HMP Garth. He was 60 years old. I offer my condolences to Mr Ferguson's family and friends.

4. Mr Ferguson almost certainly caught the infection at Garth as he had not left the prison for several months.

5. The clinical reviewer concluded that Mr Ferguson's clinical care at Garth was partly equivalent to that he could have expected to receive in the community. During the pandemic, appropriate steps were taken to reduce contact between prisoners in line with guidelines from HM Prison and Probation Service and Public Health England.

6. However, the clinical reviewer was concerned about Mr Ferguson's clinical management after he contracted COVID-19, as no care plan was in place; no clinical observations were taken; and, despite his clinical vulnerability, there were no healthcare checks between him reporting symptoms and his admission to hospital. The clinical reviewer also highlighted weaknesses in care before Mr Ferguson contracted the infection. Full details of his findings are in the clinical review report. We reflect the recommendations linked to the cause of Mr Ferguson's death.

7. There is a lack of clarity as to whether Mr Ferguson had been assessed as vulnerable to complications from COVID-19 and offered the opportunity to shield. We were unable to resolve this and therefore cannot be satisfied that his risk was appropriately managed. We are also concerned that an ambulance was not requested immediately in response to a medical emergency code and information was not passed promptly to the Ambulance Service call handler.

Recommendations

- The Governor and Head of Healthcare should ensure that all prisoners at risk of complications from COVID-19 are correctly identified and managed in line with national guidance.

- The Governor and Head of Healthcare should ensure that key actions and decisions are fully documented in personal and medical records.

- The Head of Healthcare should ensure that if a prisoner tests positive for COVID-19, healthcare staff create and document care plans; complete daily clinical checks; and take clinical observations at appropriate intervals.

- The Governor should ensure that an ambulance is requested immediately after a medical emergency code is called and that essential information about the prisoner's condition is promptly given to the Ambulance Service, in line with Prison Service Instruction 03/2013.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Ferguson's clinical care at HMP Garth.

9. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Ferguson's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.

10. The Ombudsman's family liaison officer wrote to Mr Ferguson's sister, his nominated next of kin, and his son, to explain the investigation. Some family members subsequently engaged a solicitor. Mr Ferguson's family also shared with this office correspondence with both HM Chief Inspector of Prisons and their Member of Parliament detailing their concerns about Mr Ferguson's health and conditions. Mr Ferguson's family asked for the investigation to consider the following questions and issues:

    - What had led to testing Mr Ferguson for COVID-19 and when was the positive test result known to him and healthcare staff?
    - How was Mr Ferguson managed after he contracted COVID-19, was a care plan in place and were risk assessments completed?
    - When was he admitted to hospital and was there a threshold for a hospital admission?
    - Were operational staff advised about monitoring him for signs of deterioration and alerting healthcare staff in the event of worsening symptoms?
    - Was there was a delay in sending Mr Ferguson to hospital?
    - On 27 November, Mr Ferguson had told his ex-wife that he had not eaten for two weeks, had not seen a clinician during that time and had found it difficult to care for himself.
    - Did Mr Ferguson fail to report his symptoms because of bullying and, if so, what action was taken?
    - What is the Prison Service policy on contacting next of kin and are prisoners asked if they want anyone else to be contacted in an emergency?
    - Why was Mr Ferguson's son not treated as his next of kin in regard to Mr Ferguson's property and money?

11. The clinical reviewer has addressed the issues relevant to Mr Ferguson's clinical care and cause of death. The non-clinical issues within the PPO's remit are covered in this report.

12. We sent a copy of our report to Mr Ferguson's sister and the solicitor acting on behalf of other family members. The solicitor made several observations on behalf of Mr Ferguson's family. We responded to the comments and questions in correspondence.

13. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted the recommendations. A copy of the HMPPS action plan is attached as an annex.

Previous deaths at HMP Garth

14. Mr Ferguson was the tenth prisoner at Garth to die since December 2018. Three of the previous deaths were from natural causes, one was self-inflicted and five were drug-related. There have since been five deaths, three from natural causes and two self-inflicted. None of the other deaths were related to COVID-19. We have previously raised the issue of delays in requesting an ambulance and providing information to the Ambulance Service call handler.

COVID-19 (coronavirus)

15. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

16. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

17. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is ‘compartmentalisation’ to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

18. Mr Trevor Ferguson was remanded to HMP Altcourse in July 2009. He was convicted of murder on 4 December and sentenced to life imprisonment, with a minimum period to serve of 17 years. On 10 September 2010, Mr Ferguson transferred to HMP Garth.

19. Mr Ferguson's significant medical conditions included asthma, hypertension (high blood pressure), type 2 diabetes and obesity.

20. After confirmation of the COVID-19 pandemic, it was noted in Mr Ferguson's electronic prison record (NOMIS) on 19 March 2020, that he had been identified as at "high risk" of developing complications from COVID-19 due to his long-term health conditions. Also, that he had received a letter from the Governor, giving information and advice about the risks. None of this information was reflected in his medical records and there is no evidence of discussions about shielding.

21. Over the following months, healthcare staff monitored Mr Ferguson's health conditions. He found it difficult to make dietary and lifestyle changes which meant his diabetes was poorly controlled, but he was initially unwilling to use insulin. On 4 November, a sessional GP noted that Mr Ferguson had changed his mind and an appointment would be booked with the prison GP.

22. At lunchtime on 25 November, a wing officer noticed that Mr Ferguson did not look well. He told the officer he had struggled to get out of bed, had a cough and was sweating and shivering, but had not reported this sooner due to pressure from other prisoners on his spur. She told him to self-isolate in his cell and contacted healthcare.

23. A nurse assessed Mr Ferguson and noted that he had lost his taste and smell but was breathing normally. She took a swab for testing (which returned as positive on 26 November). The nurse advised Mr Ferguson to inform healthcare if his symptoms worsened and asked wing staff to monitor him. No further clinical checks were conducted between 25 and 29 November, but wing staff completed welfare checks three times a day.

24. An entry in the wing observation book on 25 November, noted that there were prisoners on every spur who had not reported symptoms of COVID-19, for fear of a prison lockdown. Previous entries also had brief references to peer pressure, aggression, agitation and threats to staff from several prisoners about the prospect of a lockdown.

25. On 27 November, Mr Ferguson telephoned his ex-wife as he was distressed about his health and a lack of care. (The next day, his ex-wife raised safeguarding concerns with HM Chief Inspector of Prisons and her Member of Parliament, but the correspondence was not received until 30 November.)

26. During a welfare check on 29 November, an officer found Mr Ferguson distressed, short of breath and confused. Nurses were on the wing dispensing medications, but they had to get full PPE before entering his cell. While waiting, the officer asked Mr Ferguson if he could breathe and he shook his head. He therefore radioed a

code blue (to indicate a medical emergency in which a prisoner has difficulty breathing or is unresponsive).

27. Using the National Early Warning Score 2 (NEWS 2) assessment tool (which identifies clinical deterioration), a nurse calculated a score of 12. (A total score of 7 or over suggests high risk and requires emergency assessment by a critical care team.) The nurse found Mr Ferguson's blood oxygen saturation level was low and gave him oxygen. A few minutes after the code blue, an ambulance was requested.

28. The paramedics took Mr Ferguson to hospital, arriving at 12.30pm. He was escorted by two prison officers and double handcuffed. Shortly after their arrival, the handcuffs were substituted with an escort chain, to allow treatment. At 2.15pm, Mr Ferguson was moved to the intensive care unit. The escort chain was removed and he was sedated.

29. The same day, the prison assigned a family liaison officer, who informed Mr Ferguson's nominated next of kin, his sister, that he was in hospital in a life-threatening condition. She kept in close contact and, at the request of Mr Ferguson's sister, she also shared information with his niece, a clinician.

30. The prison began the application process for early release on compassionate grounds, but Mr Ferguson died before this was completed.

31. Mr Ferguson died at 12.22am on 9 December. The family liaison officer immediately tried to telephone his sister to break the news, but there was no response. She called again in the morning and provided support over the following weeks. The family liaison officer later contacted Mr Ferguson's son, who asked to be treated as next of kin.

32. An operational manager debriefed the escort officers and offered support. Notices were issued to staff and prisoners informing them of Mr Ferguson's death and reminding them of the support available.

33. Mr Ferguson's funeral was held on 7 January 2021. In line with national policy, the prison contributed to the expenses.

Cause of death

34. No post-mortem examination was held as HM Coroner accepted the hospital's clinical certification that Mr Ferguson had died of COVID-19 pneumonia.

Findings

Clinical Findings

35. The clinical reviewer concluded that Mr Ferguson's care at Garth was only partly equivalent to that he could have expected to receive in the community. He was concerned about the lack of clinical input after Mr Ferguson reported symptoms of COVID-19.

36. The clinical reviewer also identified deficiencies in the management of Mr Ferguson's obesity and the use of the National Early Warning Score (NEWS) 2 assessment tool. Full details of his findings are in the clinical review report. He made four recommendations and we reflect those linked to the cause of Mr Ferguson's death.

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

37. During the pandemic, prisons were expected to identify prisoners at risk of serious illness from COVID-19 and provide them with the opportunity to shield. Garth said that in March 2020, letters and information leaflets were sent to men with long-term conditions, explaining the risks and healthcare staff visited them to reinforce this.

38. The operational and healthcare accounts of Mr Ferguson's status and circumstances differ. There is no evidence in the medical record that Mr Ferguson's risk was assessed, but it is recorded in his prison record (NOMIS) that he received such a letter.

39. The Head of Healthcare told us that Mr Ferguson was not sent a letter as he did not meet the PHE criteria for shielding. However, Garth's local policy - Cohorting & Compartmentalisation Strategy during COVID-19 - states that both clinically extremely vulnerable and clinically vulnerable prisoners should be encouraged to shield and all conversations must be documented on NOMIS and medical records. Whether or not Mr Ferguson received a letter, there is no evidence that the risks or option to shield were discussed with him, in line with national guidance at that time. (The guidance has since changed.)

40. Given the discrepancy between the personal and medical records, we are not satisfied that Mr Ferguson's risk was managed appropriately, although we recognise that the differences might be due to inadequate record keeping. We recommend:

    The Governor and Head of Healthcare should ensure that all prisoners at risk of complications from COVID-19 are correctly identified and managed in line with national guidance.

    The Governor and Head of Healthcare should ensure that key actions and decisions are fully documented in personal and medical records.

Prisoners' reluctance to report symptoms of COVID-19

41. A wing officer recorded at the time that Mr Ferguson told her that he had delayed reporting his symptoms due to peer pressure. Some members of his family were sceptical that he would have done this and were concerned that the prison was using this to excuse failures in managing his care.

42. A prison manager told the investigator that prisoners had been placed in households of 16 men and if one of the cohort tested positive, the whole household had to isolate. Anecdotally, staff had heard that some prisoners had failed to report symptoms so they would not be responsible for lockdown of the whole unit. To avoid detection, they sent other people to collect their meals. This is the kind of dynamic that can exist between prisoners and does not strike us as implausible.

43. In response to these reports, the prison has implemented a new policy. If anyone fails to collect their food personally, the unit's supervising officer instructs wing staff to conduct a physical welfare check. We are therefore satisfied that the prison addressed this issue promptly and make no further comment.

44. It seems that Mr Ferguson contracted the virus at Garth, as he had not left the prison for any reason in the weeks before his diagnosis.

45. HM Inspectorate of Prisons (HMIP) published an aggregate report on the Short Scrutiny Visits they conducted in 35 different establishments between April and July 2020. Garth was not one of the prisons visited. Following these visits, HMIP reported in summary that prisons had responded swiftly and decisively to keep prisoners safe from COVID-19, and said that the restrictions imposed in March 2020 undoubtedly helped to prevent the spread of the virus. However, they also reported that social distancing was difficult in parts of many prisons because of the design of the buildings and at some sites it was very difficult to achieve.

Monitoring Mr Ferguson after he contracted COVID-19

46. During the pandemic, prison managers at Garth introduced two additional welfare checks, so each prisoner was checked in the morning, after lunch and during evening lock-up. Wing staff signed to confirm that each spur and landing had been checked. This was quality assured daily by the supervising officer and weekly by the safer custody team.

47. Our investigation found that healthcare staff did not put in place a care plan to manage Mr Ferguson's health needs after he contracted COVID-19. We were told this was an oversight. Additionally, no monitoring or clinical observations were completed in the four days between his positive test and admission to hospital. We are concerned that as a patient at high risk of complications from COVID-19, Mr Ferguson received no clinical monitoring of his symptoms. We recommend:

    The Head of Healthcare should ensure that if a prisoner tests positive for COVID-19, healthcare staff create and document care plans; complete daily clinical checks; and take clinical observations at appropriate intervals.

Emergency response

48. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, explains the actions staff should take in a medical emergency. It is a mandatory requirement that if an emergency code is called, control room staff must request an ambulance immediately. The Prison Service recently revised the PSI to clarify that staff calling emergency codes should provide relevant information for the Ambulance Service to use in the triage process. Garth's local protocol and subsequent staff notices reflect the guidance in the PSI, including the need to quickly relay key information to the Ambulance Service call handler.

49. Control room staff recorded that the code blue was called at 10.38am and they needed further details. Ambulance Service records show that the request for an ambulance was first received at 10.44am. (After a further call at 10.51am, the priority was upgraded from 2 to 1.) As with a previous investigation at Garth earlier this year, we are concerned that there was a considerable delay in both calling an ambulance and providing details of the emergency. While this did not affect the outcome for Mr Ferguson, such a delay could be critical in future cases. We recommend:

50. The Governor should ensure that an ambulance is requested immediately after a medical emergency code is called and that essential information about the prisoner's condition is promptly given to the Ambulance Service, in line with Prison Service Instruction 03/2013.

Contacting Mr Ferguson's next of kin

51. Some of Mr Ferguson's family questioned the policy on family contact as they were concerned that Mr Ferguson's children had not been automatically notified of his death. They were also unhappy about communication with the family liaison officer and the arrangements for disposing of Mr Ferguson's property and money.

52. The policies on recording next of kin details and family contact are set out in PSIs 7/2015 and 64/2011 *Early Days in Custody* and *Safer Custody*, respectively. PSI 12/2011 covers prisoners' property, with additional guidance on legal entitlements to property in PSI 64/2011.

53. The name and contact details of new prisoners' next of kin, as well as an emergency contact, should be recorded on reception and kept up to date. Prisoners are permitted to identify more than one person. In the event of serious illness or death, the prison should notify the nominated next of kin, but staff can deal with other family members who ask for information.

54. Mr Ferguson had nominated his sister as both next of kin and emergency contact. The family liaison officer notified her promptly of his admission to hospital and his death. She gave timely updates and kept detailed records of actions and events.

55. After Mr Ferguson's death, the family liaison officer was told that he had a son who wanted to be treated as the next of kin. She was cautious and consulted a prison manager (Head of Safer Custody), who initially advised her to confine contact to the listed next of kin. The manager said that she would handle the enquiries from Mr

Ferguson's son and ex-wife, who had already contacted the prison. The family liaison officer later engaged with Mr Ferguson's son.

56. The policy on property is that it should be given to the prison's executor or next of kin once the Coroner authorises this.

57. We are satisfied that the prison acted in line with Prison Service policy by initially notifying Mr Ferguson's sister as his next of kin and subsequently broadening family contact. We also note that the family liaison officer secured Mr Ferguson's property and sought advice from the Coroner about who should be legally recognised as next of kin for disposal when this was disputed.

Sue McAlister CB
Prisons and Probation Ombudsman **January 2022**

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