Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ashley Ferrie, a prisoner at HMP Fosse Way, on 13 February 2024

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ashley Ferrie died on 13 February 2024, after he was found hanging in his cell at HMP Fosse Way. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 35 years old. I offer my condolences to Mr Ferrie's family and friends.

Mr Ferrie was the first prisoner to die at Fosse Way, a new prison that opened in May 2023. During his five months there, Mr Ferrie gave no indication to staff that he was at risk of suicide or self-harm. I am satisfied that staff could not have foreseen his actions.

Although Mr Ferrie had weekly key worker sessions at Fosse Way, they were delivered by ten different officers and Mr Ferrie himself commented that he saw a different key worker each week. I cannot see how meaningful, supportive relationships can be built with such a model and I have asked the Director to review how key work is delivered at Fosse Way.

Mr Ferrie was found hanging from his cell door, despite the doors having been designed to be anti-ligature. I recommend that those involved in prison design should review whether any changes to cell door design are needed and review the frequency of cell door maintenance checks to ensure their safety features remain effective.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2024**

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Summary

Events

1. On 29 September 2022, Mr Ashley Ferrie was remanded in prison charged with drug offences. On 2 June 2023, he was sentenced to eight years in prison and moved to HMP Onley.

2. In July 2023, after an alleged split from his partner, Mr Ferrie swallowed some batteries. Staff monitored him under suicide and self-harm prevention procedures (known as ACCT) from 30 July to 8 August. By then, he had received a visit from his partner and children and seemed much better.

3. On 14 September, Mr Ferrie was moved to HMP Fosse Way. Staff had no concerns about him over the next five months.

4. Shortly after 5.15pm on 13 February, an officer carried out a routine check on all prisoners while they were locked in their cells. In his statement, the officer said that he saw Mr Ferrie on his bed. CCTV shows that he looked in briefly.

5. Around 15 minutes later, another officer unlocked all the cells on Mr Ferrie's unit. CCTV shows that the officer who unlocked Mr Ferrie did not look into the cell. A few minutes later, a prisoner went into Mr Ferrie's cell and found him hanging from the door. He alerted staff who responded quickly. They cut the ligature and immediately started CPR. Other officers and healthcare staff arrived quickly and assisted with the resuscitation attempt.

6. Paramedics arrived and continued with the resuscitation attempts. However, they were unsuccessful and at 6.39pm, the ambulance doctor pronounced Mr Ferrie's death.

7. Mr Ferrie left two notes in his cell which indicated that he intended to take his life. He said he was lonely and depressed.

Findings

8. Mr Ferrie did not show any signs that he was at risk of suicide or self-harm during his time at Fosse Way. We are satisfied that staff could not have foreseen his actions.

9. Local instructions say that staff should carry out welfare checks on prisoners four times a day, at 7.15am, 1.15pm, 5.00pm and 10.00pm, and that they should get a response from the prisoner. CCTV shows that although an officer looked into Mr Ferrie's cell briefly during the routine check at 5.15pm, he did not try to get a response from Mr Ferrie. Also, no one signed to say they had completed the 5.00pm welfare checks that day. The officer who unlocked Mr Ferrie's cell at 5.32pm did not look in so no one identified that Mr Ferrie was hanging until a prisoner found him. Evidence suggests that welfare checks are not being carried out correctly or at the appropriate times.

10. Mr Ferrie had weekly key worker sessions at Fosse Way but they were held by ten different officers during his five months there. The purpose of key worker sessions is to build a supportive relationship that can help the prisoner to progress through their sentence. We consider that this cannot be achieved if a prisoner's key worker changes frequently.

11. Despite the cell doors at Fosse Way having been designed to be anti-ligature (so that a ligature would be very difficult to attach), Mr Ferrie was found hanging from his cell door. We were told that the anti-ligature strip around the door frame needed maintenance to ensure that it remained effective. An annual check was scheduled so the door was not due to be checked until May 2024. The cell door design and frequency of maintenance checks should be reviewed.

Recommendations

- The Director should review the prison's local instructions on roll checks, unlocking and welfare checks to ensure that there are sufficient quality assurance processes in place to establish that:
    - staff are clear about the type of check required, when they should do it, and how the check should be carried out;
    - a welfare check is carried out on all prisoners at or before unlocking; and
    - staff carry out checks in accordance with the prison's local instructions and relevant national guidance.
- The Director should review the key working model in place at Fosse Way to ensure that it is delivering the desired outcomes.
- The Head of Custodial Contracts, in conjunction with the MoJ Prison Infrastructure Team and MoJ Property Directorate Technical Standards, should review:
    - Whether any changes to cell door design are needed.
    - The frequency of cell door maintenance checks needed to ensure that the anti-ligature features remain effective.

The Investigation Process

12. HMPPS notified us of Mr Ferrie's death on 13 February 2024.

13. The investigator issued notices to staff and prisoners at HMP Fosse Way informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded. Neither provided information specific to Mr Ferrie's death.

14. The investigator and the Deputy Ombudsman visited Fosse Way on 22 February 2024. They had informal discussions with the Director, Deputy Director, the Deputy Controller and the Independent Monitoring Board. They also spoke to two prisoners who were on the same wing as Mr Ferrie. The investigator obtained copies of relevant extracts from Mr Ferrie's prison and medical records, CCTV and body worn video camera (BWVC) footage, the recordings of telephone calls and radio transmissions.

15. The investigator interviewed five members of staff and one prisoner at Fosse Way in February, April and July 2024.

16. NHS England commissioned an independent clinical reviewer to review Mr Ferrie's clinical care at the prison. She jointly interviewed staff and the prisoner with the investigator.

17. We informed HM Coroner for Leicester City & South Leicestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Ferrie's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She asked if Mr Ferrie had been in a fight the night before he died which may have affected his state of mind. This has been addressed in this report.

19. Mr Ferrie's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy in the clinical review and two factual inaccuracies in relation to staff names in one of the transcripts and these have been amended accordingly.

Background Information

HMP Fosse Way

21. HMP Fosse Way opened in May 2023 and is managed by Serco. It is a local category C prison that holds adult men. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

22. There has not yet been an inspection of Fosse Way.

Independent Monitoring Board

23. 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.

24. The IMB has not yet issued an annual report for Fosse Way. The IMB chair told the investigator that as the prison was newly opened, there were only two members of the Board. The majority of the complaints the IMB received were in relation to property.

Previous deaths at HMP Fosse Way

25. Mr Ferrie was the first prisoner to die at Fosse Way.

Assessment, Care in Custody and Teamwork

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. All decisions made as part of the ACCT process about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move.

Key Events

27. On 29 September 2022, Mr Ashley Ferrie was remanded in prison, charged with drug offences. It was his first time in prison.

28. On 2 June 2023, Mr Ferrie was sentenced to eight years imprisonment. He was moved to HMP Onley on 6 July.

29. Mr Ferrie had a history of alcohol and drug misuse. He also had a history of mental health issues including possible schizophrenia, borderline personality disorder, PTSD, depression and self-harm by cutting. He was admitted to mental health units on several occasions due to drug-induced psychosis.

30. On 20 July, Onley's safer custody department received a telephone call to say that Mr Ferrie had split from his partner and he was going to kill himself. Staff checked on Mr Ferrie who said he was okay. Staff provided information to him about the support that was available if needed. They assessed that Mr Ferrie did not require suicide and self-harm monitoring (known as ACCT) at that time but that they would keep checking on him.

31. On 30 July, Onley received a call to say that Mr Ferrie had swallowed some batteries. Prison staff took him to hospital and started ACCT procedures. Mr Ferrie was discharged from hospital the next day. Staff continued ACCT monitoring until 8 August. By then he had received a visit from his partner and children, had been working with the mental health team and was feeling much better. There were no further incidents of self-harm at Onley.

HMP Fosse Way

32. On 14 September, Mr Ferrie was moved to HMP Fosse Way. His ACCT document should have travelled with him along with the rest of his prison paperwork but it did not. Onley said that they posted Mr Ferrie's ACCT document to Fosse Way, but it never arrived (they had proof of posting but Royal Mail was unable to confirm delivery). This was discovered only after Mr Ferrie's death. Onley provided us with a recreated ACCT document using notes that the case coordinator had kept.

33. A nurse completed Mr Ferrie's reception health screen when he arrived at Fosse Way. She recorded that Mr Ferrie said that he did not have any drug issues and no thoughts of suicide or self-harm. She noted that Mr Ferrie had been on an ACCT up until August but that he felt fine now. He said that he had a history of mental health problems and that he had been prescribed sertraline (an antidepressant) the day before. After consulting with a mental health nurse who had no concerns, she recorded that Mr Ferrie did not need a referral to the mental health team at that time and advised him how to self-refer if necessary. Healthcare staff prescribed sertraline a few days later.

34. On 18 September, a nurse completed a secondary health screen. She noted that Mr Ferrie said he had no concerns and was aware how to access healthcare if needed.

35. Mr Ferrie had regular key worker sessions. During those sessions, he told staff that he felt safe and settled on Houseblock C and had no thoughts of suicide or self-harm. Staff noted that he was an enhanced prisoner, enjoyed keeping busy with his job (as a servery worker and then as a wing cleaner) and had mainly positive entries in his prison record. He socialised with several prisoners and had regular contact with his family.

36. Mr Ferrie had an allocated key worker. However, he only had six sessions with her and from 27 October, he saw nine different officers for his key worker sessions. Mr Ferrie commented that he was seeing a different staff member every week. The prison told us that at that time, even though each prisoner had an allocated key worker, the prisoner would be seen by whoever was on duty on that wing/landing at the time, so not necessarily their designated key worker.

2024

37. On 5 February, an officer held a key worker session with Mr Ferrie. He noted that Mr Ferrie had no physical or mental health concerns and no thoughts of suicide or self-harm. He said he felt safe on the houseblock and got along with everyone. The officer noted that Mr Ferrie did not have a job or attend education. (Mr Ferrie had given up his job of wing cleaner in January for unknown reasons.) This was the last entry in his prison record.

38. On 9 February, a mental health nurse assessed Mr Ferrie after he told staff at the medications hatch that he was not sleeping and wanted to review his medication. He told her that, “I just want to feel a bit better” and asked to restart his antipsychotic medication (which he had previously been prescribed before he was sent to prison but was stopped when he told a prison psychiatrist that he was not sure if it had helped him). She told him that he would need to see a psychiatrist and made a referral. (The average waiting time was up to six weeks but as Mr Ferrie’s referral was not urgent, it was expected to be up to two months.) At interview she said that Mr Ferrie told her that he had symptoms of attention deficit hyperactivity disorder (ADHD) and was feeling restless and fidgety. She therefore made a referral for review by the speech and language therapist who managed the neurodiversity caseload. She noted that Mr Ferrie appeared well-kempt and that he said he had no thoughts of suicide or self-harm.

39. There was no record of Mr Ferrie being involved in an argument or fight.

Events of 13 February

40. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to the telephone calls and prison radio transmissions from 13 February. She also obtained information from the East Midlands Ambulance Service.

41. Mr Ferrie was on Houseblock C. The daily regime for prisoners on Houseblock C was that they were unlocked at around 7.45am and could access the wing; they were locked back in over the lunch period, between 12.15pm and 1.15pm; then unlocked for the afternoon until around 5.00pm; then locked back into their cells for a roll check (a routine count of all prisoners) at around 5.15pm before being

unlocked again until around 7.00pm when they were locked into their cells for the night.

42. After being unlocked on the morning of 13 February, Mr Ferrie remained in and by his cell for most of the morning. CCTV shows that for short periods he sat on seating outside his cell, speaking to other prisoners by his cell door. At one point, a prisoner hugged Mr Ferrie as they were speaking.

43. Mr Ferrie rang his partner four times that morning. It was his son's birthday, and he spoke to him during one of the calls. When Mr Ferrie spoke to his partner, he became aggressive and asked her repeatedly if she wanted or had a new partner. At one point he threatened to kill her if she got a new partner. Mr Ferrie made the last call at 11.54am and said he would call back later. He did not mention any thoughts of suicide or self-harm.

44. CCTV shows that before the lunchtime roll check, Mr Ferrie went back into his cell and closed the door.

45. The lunchtime roll check was completed at approximately 12.07pm by Prison Custody Officer (PCO) A. In his statement, he said that he saw Mr Ferrie lying on his bed as he locked his cell door. CCTV shows that at approximately 1.19pm, he unlocked the cell door and briefly looked in. Mr Ferrie did not leave his cell and no one entered his cell over the next three hours.

46. At around 4.45pm PCO B was checking that prisoners were in their cells so he could lock them in for the 5.00pm roll count. CCTV shows that when he got to Mr Ferrie's cell, he pushed the cell door slightly open. He did not appear to look into the cell. In his statement, he said that he could not see Mr Ferrie in the cell, so he left it unlocked as he thought he was still out on the wing.

47. At 5.00pm, prison staff began conducting a roll count. In his written statement, PCO A said that at approximately 5.15pm when he looked into the cell he saw Mr Ferrie lying on his bed. CCTV shows he briefly looked into the cell and locked the cell door.

48. CCTV shows that at 5.32pm, PCO B unlocked the cell door and slightly pushed it open. He did not look through the observation panel.

49. A few minutes later, a prisoner who lived next door to Mr Ferrie slightly opened Mr Ferrie's cell door and then left it. He did not enter the cell. At around 5.35pm another prisoner went into Mr Ferrie's cell and found him suspended from a ligature made from a bedsheet attached to the top corner of the cell door. He shouted for help.

50. CCTV shows several prisoners crowded around the cell door. PCO B pushed through the prisoners and entered the cell. He saw Mr Ferrie hanging from the cell door. He shouted to a colleague and pressed the general alarm. PCO A was the first to respond. PCO B shouted for his ligature knife and on the recorded radio transmission, PCO A used his radio to call an emergency radio code blue. Staff in the control room immediately called for an ambulance at 5.37pm.

51. In the cell, PCO B cut the ligature and with help from some prisoners, laid Mr Ferrie on the cell floor and he immediately began chest compressions. At approximately

5.40pm, other officers and healthcare staff responded to the radio message. Officers cleared prisoners from the immediate vicinity and assisted PCO B with resuscitation.

52. In order to have more room, staff moved Mr Ferrie from the cell to the landing outside and continued with resuscitation attempts.

53. Ambulance paramedics arrived at 6.10pm and continued with resuscitation attempts. At 6.39pm, the ambulance doctor pronounced Mr Ferrie's death.

54. Mr Ferrie left two notes in his cell that clearly indicated his intention to take his life. One said that it was "Saturday 20th" (presumed to be 20 January) and he was about to hang himself. He said that he was lonely as no one talked to him and he was very depressed.

55. Friends on Mr Ferrie's houseblock said they interacted with him daily. They said on occasions he appeared down as he spoke about possible charges, family issues and relationship struggles but never said anything specific.

56. A prisoner said that Mr Ferrie told him that he was having relationship problems and thought that his mental health was not being treated correctly.

Contact with Mr Ferrie's family

57. The prison appointed a PCO as the family liaison officer and a prison manager as the deputy. They visited Mr Ferrie's family at approximately 8.15pm on 13 February to tell them he had died and offer support. (In fact, they had already learnt of his death via the son of a friend who was also at Fosse Way.)

58. The prison contributed to the cost of Mr Ferrie's funeral, in line with national guidelines.

Support for prisoners and staff

59. After Mr Ferrie's death, the Deputy Director 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.

60. The prison posted notices informing other prisoners of Mr Ferrie'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 Ferrie's death. Managers said that safety staff stayed on the wing throughout the night and opened ACCT documents for five prisoners who were distressed. The next day, staff completed ACCT assessments and first case reviews.

Post-mortem report

61. A post-mortem examination found that Mr Ferrie died from hanging. The pathologist found no injuries to indicate that he had been assaulted or forcibly restrained prior to his death. Toxicology results showed evidence of previous mirtazapine use but there were no other significant findings.

Findings

Assessment of risk

62. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff must follow if they identify that a prisoner is at risk of suicide or self-harm.

63. Mr Ferrie was supported using ACCT procedures from 30 July to 8 August 2023 at Onley, after he swallowed some batteries. He had no more self-harm incidents at Onley and by the time he moved to Fosse Way on 14 September, he seemed more settled. He had a thorough reception screening at Fosse Way and showed no signs that he was at risk of suicide or self-harm.

64. During the next five months at Fosse Way, Mr Ferrie did not give any indication that he was at risk of suicide or self-harm. When asked by staff at various different times, he always said he had no thoughts of suicide or self-harm. He did not display any behaviour or present with any new risk factors to indicate to prison or healthcare staff that he was at an increased risk of suicide or self-harm.

65. In the days leading to his death, Mr Ferrie told his partner in telephone conversations that he was concerned about their relationship, his family and sentencing. However, he never shared his feelings with staff and did not raise any specific concerns with them. We are satisfied that staff could not have foreseen Mr Ferrie's actions.

Welfare checks

66. According to the Residential House Block Diary form in use at Fosse Way, welfare checks must be conducted four times a day at 7.15am,1.15pm, 5.00pm and 10.00pm (during roll checks) and says, "Response required from a prisoner during the welfare checks conducted to assure staff that there are no issues of concern."

67. CCTV shows that when officers checked on Mr Ferrie at 1.19pm and 5.15pm, they did not try to get a response from him. Also, no one signed the Residential House Block Diary form to show that they had carried out the 5.00pm welfare checks. The evidence we have seen in this case indicates that welfare checks are not being carried out properly. We also consider that there is a high likelihood that Mr Ferrie was hanging from his cell door when staff unlocked him at 5.32pm, but they did not notice. We recommend:

The Director should review the prison's local instructions on roll checks, unlocking and welfare checks to ensure that:

- **staff are clear about the type of check required, when they should do it, and how the check should be carried out;**
- **a welfare check is carried out on all prisoners at or before unlocking; and**

- **staff carry out checks in accordance with the prison's local instructions and relevant national guidance.**

Key worker scheme

68. HMPPS's Manage the Custodial Sentence Policy Framework requires that all prisoners should be allocated a prison officer key worker to engage, motivate and support them throughout their time in custody. Key workers should spend an average of 45 minutes each week per prisoner on key work duties, including individual time with each prisoner.

69. Although Mr Ferrie had weekly key worker sessions, he had them with nine different officers from September 2023 until his last session on 5 February 2024. On 16 December 2023, Mr Ferrie commented that he was seeing a different person each week.

70. The prison told us that when the prison was newly opened, they were struggling to provide key worker sessions with a consistent member of staff due to staffing levels. They allocated a nominal key worker but then whoever was on duty on the wing/landing at the time would carry out the key worker sessions. When interviewed, an officer told us that the prison had for a time changed the model so that officers saw their allocated prisoners for key working sessions but recently it had reverted back to the original model of whoever was on duty would carry out the sessions.

71. The purpose of the key worker relationship is to build trust and rapport. In our view, this cannot be achieved by prisoners seeing multiple different officers, especially when many prisoners find it difficult to build trusting relationships and share how they are feeling. We recommend:

    The Director should review the key working model in place at Fosse Way to ensure that it is delivering the desired outcomes.

Cell door design

72. We understand that when the cells at Fosse Way were designed, there was a focus on minimising ligature points in the cell. This included the design of the cell doors, which have a metal strip (known as an anti-ligature strip) around the door frame to reduce any gap through which a ligature could be attached.

73. Despite this safety feature, Mr Ferrie hanged himself from his cell door. The investigator spoke to senior HMPPS safety policy staff, staff responsible for new build prison design and MOJ prison infrastructure technical specialists in the property directorate about the cell door design. They said that anti-ligature strips around door frames in new build prisons such as Fosse Way should be checked and adjusted as part of a regular asset and maintenance check. At Fosse Way, the maintenance check was scheduled to take place annually, so a check had not taken place by the time Mr Ferrie died, around nine months after the prison opened.

74. We recommend:

The Head of Custodial Contracts, in conjunction with the MoJ Prison Infrastructure Team and MoJ Property Directorate Technical Standards, should review:

- **Whether any changes to cell door design are needed.**
- **The frequency of cell door maintenance checks needed to ensure that the anti-ligature features remain effective.**

Clinical care

75. The clinical reviewer concluded that the healthcare Mr Ferrie received at Fosse Way was of a good standard which was at least equivalent to that which he could have expected to receive in the community.

76. The clinical reviewer noted that Mr Ferrie received assessments from the mental health services for both his mental health needs and his capacity to make his own decisions. His request for a medication review was being processed, along with a referral to the Neurodevelopmental Disorder Services to assess his possible ADHD condition. His risk of self-harm was assessed to have been low, based on his presentation and behaviour. The clinical reviewer identified no concerns with the mental health care provided to Mr Ferrie.

Governor to note – HMP Onley

Missing ACCT document and lack of NOMIS entries

77. Mr Ferrie's ACCT document went missing after Onley posted it to Fosse Way. While Mr Ferrie's prison record (known as NOMIS) showed that an ACCT had been opened for him from 30 July to 8 August 2023, there were no entries in NOMIS about the reasons for the ACCT, or details of what was discussed at the ACCT case reviews. The ACCT case coordinator at Onley had kept some notes which enabled some ACCT documentation to be recreated after Mr Ferrie's death, but none of these notes were on NOMIS and therefore were not available to staff at Fosse Way.

78. As Mr Ferrie did not give any indication to staff at Fosse Way that he was at risk of suicide or self-harm, the fact that they did not have access to his ACCT document or any NOMIS entries about the ACCT is unlikely to have made any difference. However, the previous ACCT and details of Mr Ferrie's risk factors and triggers could have been highly relevant if Mr Ferrie had shown signs of being at risk. All significant interactions with prisoners should be recorded on NOMIS. We consider that at the very least, the reasons for opening an ACCT and basic contents of ACCT reviews should be recorded on NOMIS.

79. We bring this issue to the attention of the Governor at Onley.

Inquest

80. At the inquest, held from 4 to 10 March 2025, the jury concluded that Mr Ferrie died by suicide.

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