Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Ferris, a prisoner at HMP Haverigg, on 18 September 2024

A report by the Prisons and Probation Ombudsman

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

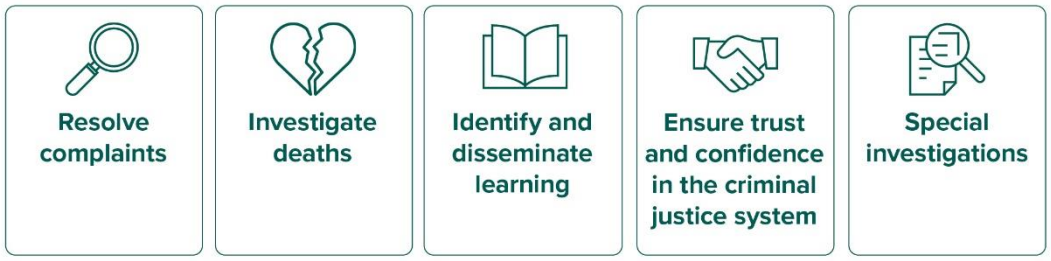
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To 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

.

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. 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.

3. On 28 March 2017, Mr Anthony Ferris was sentenced to 13 years in prison for sexual offences. He died of end stage congestive heart failure and acute kidney injury on 18 September 2024, at HMP Haverigg. He was 75 years old. We offer our condolences to Mr Ferris' family and friends.

4. The Ombudsman's office wrote to Mr Ferris' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer, to review Mr Ferris' clinical care at Haverigg.

6. The clinical reviewer concluded that the clinical care Mr Ferris received at Haverigg was predominantly equivalent to what he could have expected to receive in the community. There was one area of care she found was not equivalent but noted this was not related to his cause of death.

7. She found that Mr Ferris' medical records contained evidence of good communication and partnership working between healthcare and prison staff, and appropriate monitoring and assessment processes were in place to manage Mr Ferris' condition. He was added to the complex case register which would have positively impacted on care co-ordination.

8. The clinical reviewer made recommendations not related to Mr Ferris' death that the Head of Healthcare will wish to address.

9. The PPO investigator investigated the non-clinical issues relating to Mr Ferris' care.

10. We did not find any non-clinical issues of concern. We make no recommendations.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher **February 2025**
Prisons and Probation Ombudsman

At the inquest held on 4 April 2025 the coroner concluded Mr Athony Ferris died of natural causes.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T l 020 7633 4100