

**Prisons &
Probation**

Ombudsman

+ Independent Investigations

Independent investigation into the death of Mr Nigel Feckey, a prisoner at HMP Fosse Way, on 23 September 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



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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 Nigel Feckey was found hanged in his cell at HMP Fosse Way on 23 September 2024. He was 64 years old. I offer my condolences to Mr Feckey's family and friends.

Mr Feckey, who was in prison for sexual offences and arrived at Fosse Way on 1 February 2024, complained repeatedly that he was being bullied by other prisoners after they found out about his offences. He was assaulted twice.

Mr Feckey was supported using suicide and self-harm prevention procedures (known as ACCT) for just over three weeks in June and July, after his cellmate told staff that he had tied a ligature round his neck. Mr Feckey told staff he was still being bullied. In August, staff moved Mr Feckey to a wing for over 50s and he said the bullying stopped. However, he took his life just over a month later.

When Mr Feckey was at Fosse Way it did not have a wing for vulnerable prisoners, so Mr Feckey was located with the main prison population. During the investigation, we were told that staff were not confident in challenging poor behaviour and bullying. I am aware that Fosse Way has recently introduced two units for vulnerable prisoners (mixed with mainstream prisoners), the men located on those wings still have to mix with mainstream prisoners when they are at work or education. The prison needs to monitor this carefully to assess whether vulnerable prisoners are being kept safe at Fosse Way.

My investigation also found failings with the ACCT management including missed ACCT reviews and supervisor checks. This suggests a lack of management oversight and inadequate quality assurance.

There was a delay in finding Mr Feckey as the officer on duty that morning failed to carry out the morning roll check, even though he had signed to say he had done it. I would have recommended a disciplinary investigation, but the officer has since resigned.

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

June 2025

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Summary

Events

1. On 12 January 2024, Mr Nigel Feckey was sentenced to four years in prison for sexual offences. It was Mr Feckey's first time in prison.
2. On 1 February, Mr Feckey was moved to HMP Fosse Way. Fosse Way did not have a vulnerable prisoners' wing (often reserved for prisoners convicted of sexual offences) at that time, so Mr Feckey was located with the main prison population.
3. On 17 February, Mr Feckey told staff that other prisoners had found out about his offences and were bullying him. Throughout February, Mr Feckey's sister called the safer custody line and told staff that Mr Feckey was being bullied.
4. On 21 March, a prisoner went into Mr Feckey's cell and threw boiling water over him, causing a burn to his thigh. Mr Feckey was moved to C Wing.
5. During April and May, Mr Feckey told his key worker that the bullying had stopped.
6. On 19 June, Mr Feckey's cellmate told staff that Mr Feckey had made a ligature from a shoelace and had tied it round his neck. Staff started suicide and self-harm prevention procedures (known as ACCT). Mr Feckey told staff that he was still being bullied.
7. Staff moved Mr Feckey to a quieter landing but Mr Feckey's sister continued to call the safer custody line to report that Mr Feckey was still being bullied. Staff continued to monitor Mr Feckey under ACCT until 11 July. However, there is no record of a case review or the reasons why ACCT monitoring was stopped.
8. ACCT monitoring was restarted on 12 July after a teacher at the prison recorded that Mr Feckey said he intended to take his life. Staff held an ACCT review on 15 July and recorded that Mr Feckey said he had not meant what he had said, and he was feeling positive with no thoughts of self-harm. Staff stopped ACCT monitoring.
9. On 15 August, staff moved Mr Feckey to B Wing, a newly opened wing for prisoners aged over 50. Mr Feckey told staff that he was happy on B Wing, felt safe and was no longer being bullied.
10. At around 7.34am on 23 September, an officer started unlocking prisoners for work. When she opened Mr Feckey's cell door, she saw him lying on the floor with a ligature tied round his neck. Staff started CPR. A prison paramedic responded and assessed that Mr Feckey had rigor mortis. At 7.42am, staff stopped CPR and the paramedic pronounced life extinct.

Findings

11. There is no record of any ACCT reviews between 21 June and 15 July, including when ACCT monitoring was stopped on 11 July. Supervisor checks were missed, suggesting a lack of management commitment to the ACCT process. Although the

prison has introduced a quality assurance process, it is unclear from the records what action has been taken when quality issues have been identified.

12. Fosse Way has an offence neutral ethos and at the time of Mr Feckey's death, did not have a vulnerable prisoners' unit. Mr Feckey was repeatedly bullied and assaulted while at Fosse Way. A nurse told us that other prisoners convicted of sexual offences were also being bullied and assaulted by other prisoners. Staff told the investigator that there were a lot of new officers at the prison who did not have the confidence to challenge prisoners about their behaviour so much of it went unreported and unchallenged.
13. Fosse Way has recently introduced two units for vulnerable prisoners (the unit is mixed with mainstream prisoners), the vulnerable men located on those units still have to mix with mainstream prisoners for parts of the regime, such as work and education. Most other prisons with vulnerable prisoner units keep the prisoners separate for the entire regime so that they do not mix with mainstream prisoners at all. Fosse Way will need to monitor whether it is keeping vulnerable prisoners safe.
14. An officer signed to say that he had completed the 6.00am routine roll check when he had not. He said that he had been working alone due to staff shortages and had not had time to complete the morning roll check. We referred the matter to the police who took no further action. The officer resigned from his position.
15. Staff did not feel supported after Mr Feckey died. Prison managers sent a generic email to all staff informing them of Mr Feckey's death, which contained details of how to seek help if needed. We consider this inadequate, particularly for staff involved in the emergency response.
16. The clinical reviewer concluded that overall, the care that Mr Feckey received was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Director should undertake a review of the ACCT quality assurance process to satisfy himself that when issues are identified, appropriate remedial actions are taken in response.
- The Director should review whether:
 - Vulnerable prisoners feel safe enough to leave the wing to attend activities.
 - Staff have the confidence to challenge poor behaviour including bullying.
- The Director should ensure that staff receive adequate support after a serious incident.

The Investigation Process

17. HMPPS notified us of Mr Feckey's death on 23 September 2024.
18. 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. One prisoner responded.
19. The investigator visited Fosse Way on 30 September. She obtained copies of relevant extracts from Mr Feckey's prison and medical records.
20. NHS England commissioned a clinical reviewer to review Mr Feckey's clinical care at the prison. She and the investigator conducted joint interviews with eleven members of staff.
21. We informed HM Coroner for Leicester City and 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.
22. The Ombudsman's office contacted Mr Feckey's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She asked:
 - Why was Mr Feckey not on a wing for vulnerable prisoners?
 - What support was Mr Feckey given for his mental and physical health?
 - Why did the prison not assist Mr Feckey in pressing charges when he was burnt with hot water?
 - Who was the last person to see Mr Feckey alive?
23. These issues have been addressed in the report. Mr Feckey's sister also asked about aspects of Mr Feckey's healthcare, which have been addressed in the clinical review.
24. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.
25. We sent a copy of our initial report to Mr Feckey's next of kin. They did not notify us of any factual inaccuracies.

Background Information

HMP Fosse Way

26. 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

27. The first inspection of Fosse Way was in March 2025. HMIP have not yet published their report.

Independent Monitoring Board

28. 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 May 2024, the IMB reported that during the first operational year, the IMB had been monitoring Fosse Way with an average of just two experienced members and with just one experienced member for the last three months of the reporting period. This meant that the usual IMB duties had not been carried out and in-depth reviews of many of the prison functions had not been possible.
29. The IMB reported that the opening of Fosse Way was considered successful and, except for industries and education, opening objectives were achieved. The IMB's only real issue during this time was missing property coming from other prisons.
30. With the prisoner intake to Fosse Way increasing from around 25 to around 90 prisoners per week, the prison reached operational capacity five weeks early, in February 2024. This impacted on the workforce. Except for those seconded from other prisons, staff were new to prison work and approximately 85% were in the 18-30 age bracket. With the speedy increase in the prisoner population, pressure on young, inexperienced staff was high; and with staff levels reducing, the pressure and strain increased. In the IMB's opinion, this had resulted in ongoing staff retention issues, which had impacted on the regime at times during the reporting year.

Previous deaths at HMP Fosse Way

31. Mr Feckey was the fifth prisoner at Fosse Way to die since it opened in May 2023. Of the previous deaths, two were from natural causes, one was self-inflicted and one was an alleged homicide. We have previously made recommendations to Fosse Way about staff conducting routine roll checks (checks conducted at set points during the 24-hour period, primarily for security, to assure that that the right number of prisoners is in each part of the prison, but also serving as an opportunity to check welfare).

Assessment, Care in Custody and Teamwork

32. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or 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.
33. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions 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. When Mr Feckey was at Fosse Way, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Key Events

34. On 12 January 2024, Mr Nigel Feckey was sentenced to four years in prison for sexual offences. He was sent to HMP Nottingham. It was Mr Feckey's first time in prison.
35. On 1 February, Mr Feckey was moved to HMP Fosse Way. At that time, Fosse Way did not have a separate wing for vulnerable prisoners, so Mr Feckey was located on a standard wing. Mr Feckey told a nurse that he had a history of PTSD, anxiety, and depression. He was prescribed sertraline (an antidepressant).
36. On 17 February, Mr Feckey told staff that other prisoners were bullying him and calling him names. Staff told Mr Feckey to put in an application to see safer custody and noted in the observation book that Mr Feckey was being bullied.
37. On 19 February, Mr Feckey's sister called the safer custody line and told staff that she was concerned for Mr Feckey's safety. A Prison Custody Officer (PCO) from safer custody saw Mr Feckey for a welfare check. Mr Feckey told her that he did not feel safe on the wing and stayed in his cell most of the time. She recorded that Mr Feckey said he had no thoughts of self-harm.
38. On 21 and 29 February, Mr Feckey's sister called the safer custody line and told staff that she was still worried about Mr Feckey and that he was being bullied. After each call, safer custody staff recorded that they saw Mr Feckey for a welfare check and that he said he was being bullied. Safer custody staff called Mr Feckey's sister back and told her that Mr Feckey had given names of prisoners that were bullying him, and that staff would investigate further. They also told Mr Feckey's sister that he was safe and well.
39. On 29 February, a PCO from safer custody saw Mr Feckey. Mr Feckey told him that he was under threat on the wing and prisoners call him a 'paedo'. He said that on 26 February, he was pushed into a washing machine in the laundry room and his tooth had cracked, and that he was sexually assaulted. Mr Feckey also said that when he went to collect his dinner, other prisoners working on the servery sometimes refused to give him any food. The PCO told Mr Feckey that he would check CCTV, inform wing staff and ask safer custody to investigate. Staff subsequently reviewed the CCTV footage and recorded that they could not corroborate Mr Feckey's version of events. No further action was taken.
40. On 5 March, a nurse saw Mr Feckey. He told her that he had previously been bullied, but that officers had dealt with it and he was feeling much better. She noted that Mr Feckey showed some signs of autism and referred him to the neurodiversity team.
41. According to an intelligence report, on 21 March, a prisoner went into Mr Feckey's cell and threw a kettle of water over him. That evening, a PCO saw Mr Feckey to check he was okay. She noted that Mr Feckey said he had no injuries from the assault. The following day, Mr Feckey was moved to C Wing.
42. On 23 March, a nurse saw Mr Feckey because he was complaining of a burn to his leg. Mr Feckey told her that a prisoner had thrown hot water over him two days before. She recorded that Mr Feckey had a first degree (mild) burn to his thigh. She

applied a burns gel and a dressing. Mr Feckey identified the prisoner who assaulted him and an adjudication was held. The prisoner was given 14 days cellular confinement.

43. On 1 April, a PCO saw Mr Feckey for a welfare check. Mr Feckey asked the PCO how he could press charges against the prisoner who threw hot water over him. The PCO told Mr Feckey that he should contact his legal team. Mr Feckey said that he had already contacted his solicitor and was waiting for a response.
44. Throughout April and May, Mr Feckey had regular key worker sessions and safer custody conducted several welfare checks. Mr Feckey told staff that the bullying had stopped, and he felt safe on the wing.

ACCT – 19 June to 15 July

45. On 19 June, Mr Feckey's cellmate told staff that Mr Feckey had made a ligature from a shoelace and tied it round his neck. Mr Feckey told staff that he was feeling depressed because he was being bullied again. Staff started suicide and self-harm monitoring (known as ACCT) and set observations at two an hour.
46. On 20 June, a Custodial Operations Manager (COM) held a multidisciplinary ACCT review. Mr Feckey told staff that he was feeling depressed because he was being bullied. She told Mr Feckey that she would contact safer custody to arrange for him to be moved to a different wing. The case review team increased observations to three an hour and arranged a case review for 24 June.
47. Later that day, staff moved Mr Feckey to F Wing.
48. On 21 June, a COM held an ad hoc multidisciplinary case review. Mr Feckey said that since moving wings, he had already been threatened. Mr Feckey said that he was feeling anxious and had thoughts of self-harm. The COM told Mr Feckey that he would move him to a different landing that was quieter and more settled. Mr Feckey was later moved to a different landing and ACCT monitoring continued with three observations an hour. There are no further ACCT reviews recorded.
49. The ACCT document shows that staff continued to monitor Mr Feckey three times an hour until 28 June, when observations reduced to one an hour. The ACCT document shows that on 5 July, observations reduced to one every two hours but then increased to one an hour on 7 July. As there is no record of an ACCT review, it is unclear why observations changed on each occasion or who changed them.
50. Between 21 June and 10 July, Mr Feckey's sister called the safer custody line five times and told staff that Mr Feckey was being bullied and that she was worried about him. Staff carried out a welfare check after each call and recorded that Mr Feckey said he was okay. They called Mr Feckey's sister to tell her. There is no evidence of any action to investigate or address the allegations of bullying was taken.
51. On 11 July, a COM recorded on Mr Feckey's case notes that ACCT monitoring had stopped. There is no record of an ACCT review or any record of how the decision to end ACCT monitoring was made.

52. On 12 July, a teacher at Fosse Way recorded that when Mr Feckey was told that he would have to enrol on the next cohort for a course he wanted to do, he said that he would take his life. She re-opened Mr Feckey's ACCT. A PCO recorded on the ACCT care plan that observations were set at two an hour. There is no record that the PCO spoke to Mr Feckey and the immediate action plan was not completed until 15 July.
53. On 15 July, two COMs held an ACCT review. Mr Feckey said that he did not know why he was being monitored on an ACCT again. Mr Feckey said that he was feeling positive and had no thoughts of self-harm. Mr Feckey said that there had been a mistake in education, and he did not mean what he had said to the teacher, and he did not need to be monitored under ACCT. One of the COMs agreed to stop ACCT monitoring.

August to September

54. On 15 August, Mr Feckey was moved to B Wing, a wing that had just opened for prisoners aged over 50.
55. On 14 September, Mr Feckey's sister called the safer custody line and told staff that she was concerned about Mr Feckey's health. A PCO saw Mr Feckey for a welfare check and he told her he was feeling 'marvellous' and felt safe on B Wing.
56. Mr Feckey continued to tell staff that he wanted to press charges against the prisoner who had thrown hot water over him and in mid-September, an officer contacted the police liaison officer (PLO). The PLO saw Mr Feckey and said that he would return to take a formal statement. (This was not done before Mr Feckey died.)
57. On 21 September, a PCO saw Mr Feckey for a key worker session. Mr Feckey told her that he had no thoughts of suicide or self-harm and that he felt safe on B Wing. She reminded Mr Feckey about the support that was available should he need it.
58. At around 5.15pm on 22 September, a PCO completed the afternoon roll check. CCTV shows that the PCO looked through the observation hatch of Mr Feckey's cell. He raised no concerns. This is the last time Mr Feckey was seen alive.
59. At around 9.00pm, PCO A completed the evening roll check. CCTV shows that he turned the handle on Mr Feckey's cell door to check it was locked. He did not open the observation panel or otherwise try to visually check Mr Feckey. In his police statement, he said he called to Mr Feckey through the cell door, and he responded. He said he would have opened the observation hatch if he had got no response. CCTV shows him opening observation hatches on other cell doors.

Events of 23 September

60. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to staff radio communications from 23 September. She also obtained information from East Midlands Ambulance Service. The following account has been taken from all sources.

61. PCO A signed to say he had completed the morning roll check at 6.00am. However, CCTV shows that he did not complete the check. In his police statement, he said that there should have been two officers on duty but, due to staff shortages, he was working alone. He said that it had been a busy night on the wing and that he had not had time to complete the roll check.
62. At around 7.34am on 23 September, PCO B started unlocking prisoners for work. When she opened Mr Feckey's cell door, she saw that he was lying unresponsive on the floor with a ligature tied round his neck.
63. PCO B radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately). A COM responded around a minute later, and they both went into the cell and cut the ligature from Mr Feckey's neck.
64. The COM started CPR until a nurse arrived and took over. A prison paramedic also responded to the code blue. When she arrived, she assessed that Mr Feckey had rigor mortis (stiffening of the body after death), as he was stiff and cold. At 7.42am, she pronounced life extinct.

Contact with Mr Feckey's family

65. At around 9.00am on 23 September, an Assistant Director appointed a PCO and a COM as family liaison officers. They went to Mr Feckey's sister's address to break the news of his death.
66. The PCO maintained contact with Mr Feckey's sister and offered ongoing support. The Prison Service contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

67. After Mr Feckey'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. When staff were interviewed, they said that they did not feel that they were supported by prison managers or the care team and that no one contacted them after Mr Feckey died.
68. The prison posted notices informing other prisoners of Mr Feckey'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 Feckey's death.

Post-mortem report

69. The post-mortem report concluded that Mr Feckey died from low level ligature suspension.

Findings

Management of ACCT

70. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was in force at the time of Mr Feckey's death, set out the processes (known as ACCT) that staff should follow when they identified that a prisoner was at risk of suicide and self-harm. (The policy has since been superseded by the Prison Safety Policy Framework though ACCT processes remain broadly the same.)
71. Staff started ACCT monitoring for Mr Feckey on 19 June, after his cellmate told them that he had tied a shoelace round his neck. Staff stopped ACCT monitoring on 11 July but restarted it on 12 July, when Mr Feckey told a teacher that he intended to end his life. After a review on 15 July, the ACCT was closed.
72. There is no record of any ACCT reviews between 21 June and 15 July, including when ACCT monitoring was stopped on 11 July.
73. At interview, the investigator asked the case manager why there was no record of any ACCT reviews between 21 June and 15 July. He said that it was the first ACCT he had managed and although he had received training, he had not shadowed another case manager and lacked experience.
74. A COM said that he remembered holding ACCT reviews, and that he recorded the ACCT reviews on paper. When the investigator asked him where the paper copies of the reviews were, he said that he did not know, and thought they might have been misplaced. Without recorded ACCT reviews, it is impossible for us to consider whether decisions to increase and decrease observation frequencies were appropriate and based on the risk presented, or to understand what staff understood of Mr Feckey's risk of suicide.
75. Observations and conversations were mostly well documented in the ACCT, but there were missing supervisor checks which suggests a lack of management commitment to quality assuring the ACCT process. If there had been sufficient quality checks, it would have become apparent that there were missing ACCT reviews.
76. In addition, when staff restarted ACCT monitoring on 12 July, the immediate action plan should have been completed within one hour and an ACCT review should have been held within 25 hours. Neither were completed until 15 July.
77. The Head of Safety, who had recently taken over the role, told the investigator that he had identified a need for ACCT quality assurance checks, and that all ACCTs were now quality checked by a prison manager weekly. He said that any issues identified were discussed with the COM on the relevant houseblock.
78. The prison shared copies of the quality checks with the investigator, and while it showed that issues had been identified, it did not specify the action that had been taken. We consider that the quality assurance form should be updated so it is clear what action has been taken to address any identified quality issues.

79. We make the following recommendation:

The Director should undertake a review of the ACCT quality assurance process to satisfy himself that when issues are identified, appropriate remedial actions taken in response.

Bullying of vulnerable prisoners

80. Many prisons have Vulnerable Prisoner Units (VPUs), which keep prisoners at risk from others separate from the main prison population. Prisoners convicted of sexual offences are often placed on the VPU as the nature of their offences puts them at risk of threats and assault by other prisoners.
81. When Mr Feckey was at Fosse Way, it did not have a VPU. Fosse Way was described as an offence neutral prison and the prison's ethos was that all prisoners, regardless of their offence, were integrated.
82. A nurse at Fosse Way told the investigator that prisoners, most of whom were sex offenders, frequently told healthcare staff that they were being bullied. The nurse said that all allegations of bullying were reported to safer custody.
83. Mr Feckey and his sister repeatedly told staff that he was being physically and verbally bullied. He was also assaulted twice. There is very little evidence that staff took any meaningful action (other than moving Mr Feckey to another wing or landing) to challenge or address the bullying.
84. A prison manager told the investigator that there were a lot of young, inexperienced staff at Fosse Way who lacked confidence in challenging prisoners' behaviour. The manager also told us that bullying was mostly targeted at prisoners convicted of sexual offences.
85. In March 2025, Fosse Way introduced two units for vulnerable prisoners. Moves there were voluntary and vulnerable prisoners could choose to stay on a mainstream wing if they wished. Men located on the vulnerable prisoner units must leave the unit to attend activities such as work and education, which are mixed with mainstream prisoners. This is different to many other prisons with VPUs, which generally offer completely separate regimes for vulnerable prisoners, so they never mix with mainstream prisoners. The model at Fosse Way will need to be monitored to assess whether it is keeping vulnerable prisoners safe. We make the following recommendation:

The Director should review whether:

- **Vulnerable prisoners feel safe enough to leave the wing to attend activities.**
- **Staff have the confidence to challenge poor behaviour including bullying.**

86. When Mr Feckey asked staff how he could press charges against the prisoner that assaulted him they should have promptly directed Mr Feckey to the Police Liaison Officer (PLO) who is based in the prison, and the PLO would have taken a statement from Mr Feckey and considered whether criminal charges could have

been made. Staff told Mr Feckey that if he wanted to press charges, he would need to contact his legal team, which he had already done.

87. Mr Feckey continued to tell staff that he wanted to press charges and after six months an officer contacted the PLO. Several days before Mr Feckey died, the PLO saw Mr Feckey and said that he would come back to take a formal statement. This had not happened before Mr Feckey died. We bring this issue to the Director's attention.

Roll checks

88. 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). The form says, "Response required from a prisoner during the welfare checks conducted to assure staff that there are no issues of concern."
89. We are satisfied that a PCO checked on Mr Feckey during the 5.15pm roll check on 22 September. This was the last time Mr Feckey was seen alive.
90. PCO A did not carry out an adequate check at 9.00pm that evening, as he did not look into Mr Feckey's cell. Even if he got a verbal response from Mr Feckey as claimed, he should have carried out a visual check too. CCTV footage shows that he did not carry out the 6.00am check the next morning, even though he signed to say he had.
91. We referred this to the police, who decided to take no further action. As PCO A has resigned from Serco employment, we make no recommendation.

Support for staff

92. Almost all staff that were interviewed told the investigator that they did not feel supported after Mr Feckey died. Staff said that they had not been spoken to by a TRiM practitioner or the care team. Staff said that no one had spoken to them since the debrief to ask if they were okay or if they needed further support. Staff also told the investigator that after Mr Feckey died, they continued their shift, which they found difficult.
93. After Mr Feckey's death, a generic email was sent out to all members of staff in the prison informing them of his death. The email gave details of who to contact if further support was needed. We do not think that this generic approach was enough. We recommend:

The Director should ensure that staff receive adequate support after a serious incident.

Clinical care

94. The clinical reviewer found that the care Mr Feckey received was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made two recommendations, not directly related to Mr Feckey's death, which the Head of Healthcare will wish to address.

Inquest

95. At the inquest, held from 12 to 21 January 2026, the jury concluded that Mr Nigel Feckey died by suicide.

**Prisons &
Probation**

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