

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Fyfe, a resident at Albion Street Approved Premises, on 22 May 2019

A report by the Prisons and Probation Ombudsman



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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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.

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

Mr John Fyfe died in hospital from heart disease on 22 May 2019, while a resident at Albion Street Approved Premises in Dewsbury. He was 76 years old. I offer my condolences to Mr Fyfe's family and friends.

Mr Fyfe was released from HMP Wakefield on 22 May, and he arrived at Albion Street later that morning. Soon after, he went to the shops but failed to return. He collapsed in the town centre that evening, where he was treated by ambulance paramedics, but without success.

Mr Fyfe had been diagnosed with heart disease and diabetes before he arrived at Wakefield and was prescribed appropriate medication. However, he frequently failed to take his medication and around a month before his release, he stopped collecting it. He was released from Wakefield without any medication in his possession.

The clinical reviewer found that the care Mr Fyfe received at Wakefield in respect of his medication compliance, and his subsequent release from prison, was not of the required standard and not equivalent to that he could have expected to receive in the community. A senior member of healthcare staff should have spoken to Mr Fyfe about his refusal to take his medication and reviewed the arrangements for providing him with it. The clinical reviewer also found no evidence that staff had assessed Mr Fyfe's mental capacity to refuse his medication.

I cannot say whether Mr Fyfe's failure to take his medication resulted in his death. However, he was on critical medications for heart disease and diabetes, and I consider that healthcare staff at Wakefield should have done more to monitor Mr Fyfe's medication compliance and to encourage him to take his medication. I am concerned that Mr Fyfe was released from Wakefield without any medication in his possession.

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

Sue McAllister CB
Prisons and Probation Ombudsman

December 2020

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Summary

Events

1. Mr John Fyfe was sentenced to 12 years imprisonment for sexual offences on 22 May 2013. On 11 February 2014, he was moved to HMP Wakefield.
2. Mr Fyfe had several chronic health conditions including heart disease and type 2 diabetes. He was prescribed appropriate medication but there were several occasions when he stopped taking it, sometimes for several months. On 8 May 2019, staff realised that Mr Fyfe had not collected his medication for three weeks. A healthcare assistant spoke to him and explained the importance of taking his medication. Mr Fyfe said that his medication had not been ready for him when he went to collect it, so he would not be going to collect it again.
3. On 22 May, Mr Fyfe was released from prison on licence. It was a condition of his licence that he lived at Albion Street Approved Premises in Dewsbury. He arrived there at 11.00am.
4. Staff gave Mr Fyfe permission to visit a nearby shop to buy tobacco and a walking stick. Mr Fyfe had not returned to Albion Street by 1.00pm, the time he was due to sign in, and he had still not returned by his curfew time of 7.00pm. Staff and a resident at Albion Street made efforts to find Mr Fyfe, but without success.
5. At around 7.00pm, Mr Fyfe collapsed in Dewsbury town centre. Ambulance paramedics arrived and tried to resuscitate him. At 8.12pm the paramedics declared that Mr Fyfe was dead.
6. The post-mortem examination found that Mr Fyfe died from ischaemic heart disease.

Findings

7. The clinical reviewer found that the care Mr Fyfe received at Wakefield in respect of his medication compliance, and subsequent release from prison, was not of the required standard and was not equivalent to the care he could have expected to receive in the community.
8. The clinical reviewer considered that a senior member of healthcare staff should have spoken to Mr Fyfe about his refusal to take his medication and should have considered arrangements to make it easier for Mr Fyfe to collect his medication. The clinical reviewer also found no evidence that Mr Fyfe's mental capacity to refuse his medication was ever formally assessed.
9. On 8 May, when a healthcare assistant went to see Mr Fyfe about his failure to collect his medication, it was agreed that weekly welfare checks would be carried out. These did not take place.
10. While we cannot say whether Mr Fyfe's failure to take his medication resulted in his death, we are concerned that Mr Fyfe was released from Wakefield without his critical medication for heart disease and diabetes.

Recommendations

- The Head of Healthcare at HMP Wakefield should ensure that when prisoners refuse to take critical medications:
 - a senior member of healthcare staff speaks to the prisoner and documents this in the medical record;
 - a medication in-possession risk assessment is carried out and the outcome is recorded in the medical record; and
 - the prisoner's mental capacity is assessed and the outcome is recorded in the medical record.
- The Head of Healthcare should ensure that weekly welfare checks are carried out as agreed.
- The Head of Healthcare should ensure that prisoners are provided with critical medications before their release into the community and that this is noted in their medical record.

The Investigation Process

11. The investigator issued notices to staff and residents at Albion Street Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of statements made by staff at Albion Street following Mr Fyfe's death. She interviewed Mr Fyfe's offender manager by telephone and she obtained further information in a telephone conversation with a manager who was temporarily in charge of Albion Street at the time of Mr Fyfe's death. One of her colleagues contacted HMP Wakefield and obtained relevant extracts from Mr Fyfe's prison and medical records. He also obtained further information from Mr Fyfe's offender manager.
13. Due to concerns we identified with Mr Fyfe's clinical care at Wakefield, we asked NHS England to commission a clinical review. NHS England appointed a clinical reviewer to carry out the review.
14. We informed HM Coroner for West Yorkshire (Western District) of the investigation. The coroner provided us with the post-mortem and toxicology reports. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted one of Mr Fyfe's daughters to explain the investigation and to ask her whether there were any matters she wanted the investigation to consider. She did not raise any issues.

Background Information

Albion Street Approved Premises

16. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as being a supportive and structured environment. Residents are responsible for their own health and are expected to register with a local GP.
17. Albion Street Approved Premises in Dewsbury is managed by the National Probation Service North East. It holds up to 24 men: 16 in single rooms and eight sharing four double rooms. Each resident is allocated a key worker/offender supervisor to oversee their progress and well-being and to ensure that residents adhere to their licence conditions and the premises rules. All residents have strict curfew times when they are required to be on the premises. Albion Street is staffed 24 hours a day.

HM Inspectorate of Probation

18. HM Inspectorate of Probation published in July 2017, a thematic report into the contribution made by approved premises towards public protection, rehabilitation and resettlement. The Inspectorate found that approved premises were doing a good job overall and were doing an exceptionally good job at protecting the public. The Inspectorate also noted a number of challenges faced by approved premises, including an increase in the number of elderly sex offenders with significant care needs.

Previous deaths at Albion Street

19. There have been two previous deaths of Albion Street residents, in 2011 and 2013. One was drug-related and one was a homicide.

HMP Wakefield

20. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders). Care UK provides healthcare at Wakefield.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Wakefield was in June 2018. Inspectors reported that access to healthcare services was good. Most waiting lists were acceptable. Inspectors observed caring and professional staff. A member of healthcare staff was often available at medication times to manage queries, which was a good initiative.

Independent Monitoring Board

22. 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 30 April 2018, the IMB reported that the healthcare environment had been much more settled and the teams had looked to build on improving the qualitative aspects of care for each prisoner.

Previous deaths at HMP Wakefield

23. Sixteen prisoners at Wakefield died between May 2017 and May 2019. Fifteen were due to natural causes and one was self-inflicted. There were no similarities between the findings from the investigation into Mr Fyfe's death and the investigations into the previous deaths at Wakefield.

Key Events

24. On 22 May 2013, Mr John Fyfe was sentenced to 12 years imprisonment for sexual offences and sent to HMP Doncaster. On 11 February 2014, he was moved to HMP Wakefield.
25. Mr Fyfe had several chronic health conditions, including ischaemic heart disease (where blood supply to the heart is affected by a build-up of fatty substances in the coronary arteries) and type 2 diabetes (a condition that causes the level of glucose in the blood to become too high, which increases the risk of heart disease and stroke). Mr Fyfe was prescribed atorvastatin (to lower cholesterol); clopidogrel (a blood thinner); creon (to help with digestion); metformin (to treat type 2 diabetes); colecalciferol (for vitamin D deficiency); and omeprazole (to reduce stomach acid).
26. On 6 September 2018, healthcare staff realised that Mr Fyfe had not collected his medication since June. A nurse spoke to him and explained the implications of not taking his medication, but Mr Fyfe said he did not want to take it because it made him feel no different. Another nurse met with Mr Fyfe on 11 September and explained again the implications of not taking his medication. Mr Fyfe agreed to restart it and it was agreed that he would be given it in a dosette box (which has multiple compartments divided into time and date to show which tablets need to be taken when). Normally he was provided with four weeks' worth of medication in weekly dosette boxes.
27. On 12 October, a nurse saw Mr Fyfe for a healthy lifestyle check. Mr Fyfe got very upset, handed a full dosette box to her and said he did not know how to take his medication. She noted that she explained it to him in detail.
28. On 11 December, Mr Fyfe became upset and told healthcare staff that he was not taking his medication. A healthcare assistant explained the importance of taking his medication. Mr Fyfe said that he had tried to collect his medication that morning but the pharmacy would not give it to him. She explained that weekly medication was not dispensed in the mornings but could be collected at lunchtimes. Mr Fyfe left and said he would no longer be picking up his medication. She noted that she would inform the cardiac nurse.
29. On 13 April 2019, Mr Fyfe went to collect his medication. A pharmacy technician noted that there was no dosette box for Mr Fyfe, as according to his prescription chart, he should have had another week of medication left. She told Mr Fyfe to return on the following Monday and she would make sure a dosette box was ready for him. Mr Fyfe told her not to bother as he did not want his medication anymore. She sent an urgent electronic task message for the pharmacy department to prepare Mr Fyfe's medication and to contact him when it was ready.
30. On 8 May, a note was made in Mr Fyfe's records to say that he had not collected his medication for the previous three weeks. A healthcare assistant went to Mr Fyfe's cell to speak to him. He told her that he had been told that he needed to take his medication, but when he went to collect it there was no medication for him to collect. He said that on principle, he would not collect it again. She noted that she urged him multiple times to change his mind, but without success. She noted that Mr Fyfe would be followed up by receiving weekly welfare checks. She also noted

that he would be added to the multi-professional complex case conference (MPCCC) list.

31. On 15 May, Mr Fyfe's support worker noted that she had spoken to Mr Fyfe, probably for the last time before his release from custody. Arrangements had been made for him to live at Albion Street Approved Premises in Dewsbury. He told her that he was very happy about his release.
32. On 18 May, a healthcare assistant saw Mr Fyfe to check his respiratory rate, his blood saturation level, his heart rate, his blood pressure and his temperature. All were normal apart from his blood pressure, which was high. (There is no record that this was followed up.) She also checked his 'conscious levels' and noted that he was alert.
33. Mr Fyfe had several meetings with his offender supervisor before his release from custody. The offender supervisor arranged for Mr Fyfe to have a paper copy of his prison medical records for him to take away on the day of his release.
34. Mr Fyfe was released from HMP Wakefield on the morning of 22 May. The offender supervisor said in a statement that a Custodial Manager (CM) had checked Mr Fyfe's understanding of the discharge process and warned him to be careful on his release and to avoid alcohol. He travelled with Mr Fyfe in a prison van for the short journey from the prison to the probation office. Mr Fyfe had his medical records.
35. Mr Fyfe met his offender manager at the probation office. Due to Mr Fyfe's mobility problems, she arranged a taxi to take Mr Fyfe to Albion Street. He arrived there at 11.00am.
36. A residential worker met Mr Fyfe on his arrival at Albion Street. She told him about his curfew, which was 7.00pm to 7.00am, and that he must also report to the premises each day at 1.00pm.
37. Another residential worker introduced himself to Mr Fyfe before completing welfare checks on other residents. He planned to meet Mr Fyfe later, to give him a full induction to the premises.
38. After Mr Fyfe had smoked a cigarette given to him by a third residential worker, he said that he would like to go to a shop to buy some tobacco and a walking stick. Mr Fyfe was given directions, but he found these difficult to understand. Two other residents said that they would walk with him to show him the way. They left the premises and walked to a shop close to Dewsbury town centre, which was less than 600 metres away.
39. At around 1.00pm, one of the residents returned to Albion Street and was surprised to learn that Mr Fyfe had not returned. He told staff that he saw Mr Fyfe heading back to Albion Street after he had bought tobacco. He went back into Dewsbury to look for Mr Fyfe but was unable to find him.
40. At around 2.00pm, the offender manager responded to a message left for her by a residential worker and they spoke about Mr Fyfe's failure to return to the premises. They agreed that it seemed likely that Mr Fyfe had got lost and that they would give him more time to return.

41. Mr Fyfe was due to meet the offender manager at Albion Street at 3.45pm, but he again failed to arrive. During the following few hours, a residential worker drove into Dewsbury to look for Mr Fyfe and premises staff telephoned local hospitals to check if he had been admitted. Meanwhile, the offender manager telephoned a senior probation officer and the Public Protection Unit to inform them of Mr Fyfe's absence.
42. At 7.00pm, another residential worker telephoned the police to ask if Mr Fyfe had been taken into custody. He then telephoned the on-call premises manager and told her that Mr Fyfe was still missing. She advised him to wait until 8.00pm, and to then make further calls to local hospitals and to report Mr Fyfe's absence to the police.
43. At some time around 7.00pm in Dewsbury town centre, a member of the public saw Mr Fyfe stumble and fall to the ground. The member of the public checked him, found that he was not breathing and called for an ambulance. Paramedics attempted to resuscitate Mr Fyfe, but without success and at 8.12pm they declared that he was dead. At 9.20pm, a police officer went to Albion Street and informed one of the residential workers that Mr Fyfe had died.

Contact with Mr Fyfe's family

44. Mr Fyfe's next of kin was his daughter. Police officers from her area visited her at home just before midnight to inform her of her father's death. She agreed to inform other family members. The Probation Service contributed to Mr Fyfe's funeral expenses.

Support for staff and residents

45. Senior probation staff visited Albion Street on 23 May to offer support to staff and residents who might have been affected by Mr Fyfe's death.

Post-mortem report

46. Mr Fyfe's post-mortem examination showed that he had a significant build-up of fatty deposits in the arteries around the heart (severe coronary artery atheroma). The pathologist noted that this condition had caused Mr Fyfe to suffer a heart attack in the past and put him at risk of a further heart attack. The pathologist also found that Mr Fyfe had fluid in his lungs (pulmonary oedema) which suggested that he had suffered acute cardiac failure. The pathologist gave Mr Fyfe's cause of death as ischaemic heart disease, caused by coronary artery atheroma. Results of toxicology tests showed no evidence of recent alcohol or drug use.

Findings

Mr Fyfe's clinical care at HMP Wakefield

47. The clinical reviewer found that the care Mr Fyfe received at Wakefield in respect of his medication compliance, and subsequent release from prison, was not of the required standard and was therefore not equivalent to the care he could have expected to receive in the community.
48. Mr Fyfe had a dosette box for his medication, which included critical medication for his heart disease and diabetes. The clinical reviewer noted that there were entries throughout Mr Fyfe's clinical record of him being confused, handing back his medication and refusing to take it. The clinical reviewer considered that a senior member of healthcare staff should have spoken to Mr Fyfe about his refusal to take his medication and spoken to the pharmacy about the suitability of his dosette box. They also should have considered whether arrangements could have been put in place to help Mr Fyfe collect his medication.
49. The clinical reviewer could find no evidence of any medication in-possession risk assessments (MIPRA) being done for Mr Fyfe. It is good practice for these to be done every six months, but also when circumstances change. The Head of Healthcare told the clinical reviewer that the last MIPRA done for Mr Fyfe was in May 2017. As Mr Fyfe became non-compliant with his medication, a more recent MIPRA should have been undertaken.
50. The clinical reviewer could find no evidence of mental capacity assessments within Mr Fyfe's record. She considered that an entry should have been made to confirm that Mr Fyfe had the capacity to refuse his medication and that he understood the consequences of not taking his medication.
51. We make the following recommendation:

The Head of Healthcare at HMP Wakefield should ensure that when prisoners refuse to take critical medications:

- **a senior member of healthcare staff speaks to the prisoner and documents this in the medical record;**
 - **a medication in-possession risk assessment is carried out and the outcome is recorded in the medical record; and**
 - **the prisoner's mental capacity is assessed and the outcome is recorded in the medical record.**
52. The clinical reviewer noted that Mr Fyfe did not receive weekly welfare checks after 8 May, despite the note made by a healthcare assistant. She could also find no record that Mr Fyfe was added to the weekly multi-professional complex case conference (MPCCC) list. The Head of Healthcare told the clinical reviewer that there was a four-week wait at the time (MPCCC clinics were held weekly), and that Mr Fyfe was added to the list on 23 May, the day following his discharge from Wakefield. She said that MPCCC clinics were now held daily and that there was now a report that highlighted prisoners due for release. We make the following recommendation:

The Head of Healthcare should ensure that weekly welfare checks are carried out as agreed.

Mr Fyfe's discharge from HMP Wakefield

53. Mr Fyfe was released from Wakefield on the morning of 22 May. The clinical reviewer noted that there was no record that he was seen by healthcare staff on the day of his release. He was provided with a copy of his medical records but he was released without any medication in his possession as he had stopped collecting it a few weeks earlier.
54. The nurse matron at Wakefield told the investigator that Mr Fyfe would not have suffered an immediate deterioration in health by stopping taking his medication, but it would have been important for him to resume taking some, such as his medication for type 2 diabetes. She said that at the time of Mr Fyfe's release there was no formal requirement for prisoners to be checked by the nursing team before their release to the community. She said that in September 2019, Wakefield introduced a formal process for assessing prisoners in their final weeks before release. The checks include basic physical checks, confirming that the prisoner understands how to register with a community GP, checking their medication and compliance with medication, checking whether the prisoner has any health concerns and writing a referral to an external healthcare body as needed. The matron said that the new process was not connected with Mr Fyfe's death.
55. We cannot say whether Mr Fyfe's failure to take his medication resulted in his death. We are concerned, however, that he was released into the community without critical medication for his heart disease and diabetes. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are provided with critical medications before their release into the community and that this is noted in their medical record.

Mr Fyfe's failure to report back to Albion Street

56. Mr Fyfe left Albion Street to go to the shops at 11.00am. When he failed to return for his 1.00pm sign-in, a residential worker telephoned his offender manager and left a message for her to call back. The offender manager telephoned at 2.00pm and they agreed that the most likely explanation, given Mr Fyfe's earlier confusion, was that he had got lost. Mr Fyfe had still not returned by the time he was due to meet the offender manager at 3.45pm and staff at Albion Street made efforts to try to find him by telephoning local hospitals, telephoning the police to see if he had been taken into custody and a residential worker drove into Dewsbury to try to find him. Another resident at Albion Street also tried to find Mr Fyfe.
57. We consider that Albion Street made reasonable efforts to try to locate Mr Fyfe.
58. When Mr Fyfe missed his scheduled meeting with his offender manager at 3.45pm, she informed a senior officer and the Public Protection Unit. Staff at the premises made efforts to check if Mr Fyfe had been admitted to hospital but a decision was made to wait until 8.00pm before formally notifying the police of Mr Fyfe's absence.

59. When a resident at an approved premises fails to comply with their licence conditions, the Probation Service can instigate proceedings to recall them into prison custody. They might also need to involve the police if it is believed that the resident poses a risk to the general public. The offender manager told the investigator that she would not instigate recall procedures solely due to a resident missing their 1.00pm sign in time. She also said that a factor she bore in mind with Mr Fyfe in considering police involvement was that his offences had occurred many years before, his victims were known to him and not strangers, and, by 2019, Mr Fyfe was elderly and fairly infirm.
60. We consider that it was reasonable in the circumstances to delay formal notification to the police of Mr Fyfe's absence. In reaching this finding, we take into account the likelihood that the police would not have considered Mr Fyfe's absence to be a priority even had they been informed earlier in the afternoon.

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