Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malcolm Fairley, a prisoner at HMP Hull, on 28 May 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

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. In February 1985, Mr Malcolm Fairley was sentenced to life imprisonment for sexual offences. He died of a recent heart attack caused by coronary artery occlusion (a build-up of plaque in the arteries of the heart) on 28 May 2024 at HMP Hull. He was 71 years old. We offer our condolences to Mr Fairley's family and friends.

4. The Ombudsman's office wrote to Mr Fairley's next of kin, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Fairley's clinical care at HMP Hull.

6. The clinical reviewer concluded that the clinical care Mr Fairley received at Hull was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. She found that Mr Fairley did not have regular risk assessments to determine whether it was appropriate for him to keep and administer his medication and there was a delay in reviewing one of his long-term conditions. However, the clinical reviewer made no recommendations as work was actively being undertaken to address these concerns.

7. The PPO investigator investigated the non-clinical issues relating to Mr Fairley's care. She and the clinical reviewer interviewed four members of prison and healthcare staff between 3 and 5 July 2024.

8. We did not identify any non-clinical issues of concern and we make no recommendations.

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

10. At an inquest held on 23 September 2025, the Coroner concluded that Mr Fairley died of natural causes.

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

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