Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Imogen Mellor, a prisoner at HMP/YOI Styal, on 4 June 2018

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.

Ms Imogen Mellor was found hanging in her shared room at HMP Styal on 4 July 2018 and died that evening in hospital. She was 29 years old. I offer my condolences to Ms Mellor's family and friends.

Ms Mellor was very dependent emotionally on her relationship with her partner (a fellow prisoner) and had had a heated argument with her shortly before she died. However, staff were not aware of this. I am satisfied there was little to indicate that Ms Mellor was at imminent risk of suicide, and I do not consider that staff at Styal could have predicted that Ms Mellor intended to take her own life when she did.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **February 2023**

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Summary

Events

1. In November 2014, Ms Imogen Mellor was sentenced to four years and eight months imprisonment. She was released in April 2016 but recalled to prison in August 2017 after committing further offences while on licence. She was released again on 5 April 2018 and recalled again on 28 April after she breached the conditions of her licence. She was returned to HMP Styal to complete her sentence. She was due to be released on 13 August 2018.

2. Ms Mellor had a history of substance misuse and of self-harm from 2017. She had been managed under suicide and self-harm management procedures (known as ACCT) earlier in her sentence, mostly recently in January 2018, after she cut herself. She said she had self-harmed to cope with stresses caused by her relationship with her partner (a fellow prisoner). When she returned to Styal in April 2018, she began a methadone detoxification programme for her heroin misuse.

3. Around 3.00pm on 4 June 2018, Ms Mellor had a heated argument with her partner, and returned to her residential house. Her partner shouted up at Ms Mellor's room window but, when Ms Mellor did not respond, she alerted an officer who went to Ms Mellor's room.

4. The officer found Ms Mellor hanging from a ligature around her neck which was attached to the bunk bed ladder. The officer called for medical assistance using her radio. Nursing staff arrived quickly and tried to resuscitate her. Ms Mellor was taken to hospital but died at 10.30pm that evening.

Findings

Clinical Care

5. The investigation found that the standard of clinical care provided to Ms Mellor was equivalent to that which she could have expected to receive in the community, especially for her mental health and support for substance recovery.

Identifying risk of suicide and self-harm

6. Ms Mellor's offender manager (probation officer) was concerned that Ms Mellor was very dependent on her partner, and, in April 2018, she said that Ms Mellor would be at risk of serious self-harm if their relationship ended.

7. While Ms Mellor had some risk factors for suicide and self-harm, we are satisfied that in the days leading to her death, there was nothing to indicate that she was at increased risk. Staff were not aware that she had argued with her partner, and we do not consider that they could have foreseen her death.

Emergency response

8. The officer who found Ms Mellor unresponsive in her room radioed for assistance and an ambulance at 3.44pm but did not use an emergency response code. Although in practice this did not cause a delay before an ambulance was called and CPR was initiated, it could make a critical difference in other medical emergencies.

Recommendations

- The Governor should remind all staff that they should use the appropriate emergency medical code to communicate the nature of the emergency efficiently.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Styal informing them of the investigation and asking anyone with relevant information to contact him. One person asked to speak to him.

10. The investigator visited Styal on 20 June 2018. He obtained copies of relevant extracts from Ms Mellor's prison and medical records and interviewed four prisoners, including Ms Mellor's partner.

11. Another investigator took over the investigation in August. She interviewed eleven members of staff in September and October 2018.

12. NHS England commissioned a clinical reviewer to review Ms Mellor's clinical care at the prison. The clinical reviewer conducted seven joint interviews with the investigator.

13. We informed HM Coroner for Cheshire of the investigation. We suspended the investigation until we received the results of the post-mortem investigation. We have sent the coroner a copy of this report.

14. The investigator contacted Ms Mellor's parents to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. Ms Mellor's mother asked what her daughter had used as a ligature and whether the healthcare emergency response was appropriate. Her father asked if staff should have prevented her from taking her life.

15. We have addressed these questions in this report. Following the publication of our initial report Ms Mellor's family responded and raised some questions regard the findings of both our investigation and that of the clinical review. The family questions have been responded to in separate correspondence.

16. An inquest was concluded in May 2024 and found the following:

> '… Ms Mellor deliberately chose to ligature, with the physical evidence suggesting suicide, however the true extent of Ms Mellor's desire to live or die cannot be determined …'

Background Information

HMP Styal

17. HMP and YOI Styal is a women's prison in Cheshire which holds up to 486 women. There is a variety of residential units, including 16 separate houses each holding about 20 women in shared rooms.

18. Spectrum Community Health runs healthcare services at the prison. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. There are nurses on duty at all times, with one registered nurse and a healthcare support worker available at night. GP sessions are held every day except Sundays when there is an out of hours service. There is no inpatient facility.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Styal was in May 2018. Inspectors reported that women were well cared for when they arrived at Styal and induction was thorough. Nearly all the women arrived with significant need including a history of suicide attempts and self-harm, mental health, and substance misuse issues. They found that the management of prisoners on ACCTs was good. The availability of illicit substances was high and over 50% of women said they had a drug problem on arrival. However, inspectors found that the drug supply reduction strategy was practical, well informed and focused on supporting women, alongside preventative measures.

20. Levels of self-harm were very high due to a small number of women who harmed themselves prolifically, but the vast majority of staff were caring and supportive and inspectors were confident that most women had a member of staff they could turn to if they had an issue. Most safety incidents or problems were related to the breakdown of or tensions within relationships among the women, but levels of violence were low.

Independent Monitoring Board

21. 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 April 2018, the IMB reported that appropriate care was given to new prisoners in reception and the first night centre. They found that ACCT procedures were generally being used effectively.

Previous deaths at HMP Styal

22. Ms Mellor's death was the first self-inflicted death at Styal since 2016. There have been two further self-inflicted deaths in 2019, and two deaths from natural causes in 2020.

Assessment, Care in Custody and Teamwork

23. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).

Key Events

24. In November 2014, Ms Imogen Mellor was sentenced to four years and eight months imprisonment for conspiracy to supply class A drugs.

25. She had a history of crack cocaine, heroin, and benzodiazepine misuse since the age of 15. She also had a history of self-harm and suicidal thoughts and had taken an overdose when she was 16 years old. While in custody, Ms Mellor was diagnosed with an eating disorder, dissocial personality disorder, and mixed anxiety and depressive disorder.

26. Ms Mellor met her partner (Prisoner A) at HMP Peterborough in 2015. She was released on licence in April 2016 and her relationship with Prisoner A continued in the community.

HMP Styal – 12 August 2017 to 5 April 2018

27. In August 2017, Ms Mellor was recalled to prison on further charges of robbery and assault and was taken to HMP Styal. She tested positive for opiates and methadone. She subsequently completed detoxification treatment and remained on methadone maintenance therapy, gradually reducing her methadone intake.

28. In September and October, Ms Mellor was managed under ACCT procedures after she made cuts to her arm on several occasions. She said that she was feeling very low because she thought she might get a long sentence at her upcoming trial while Prisoner A, who was her co-defendant, walked free. She also said she was upset because she was unable to communicate with Prisoner A, who was also in Styal, as they were co-defendants.

29. A comprehensive caremap was put in place to provide support with the issues that Ms Mellor had raised. In October, Ms Mellor met with mental health nurse, who had been assigned as her case worker. Ms Mellor was very tearful and said that she had been self-harming and making herself vomit after each meal because she felt she had no control over her life. She said she was worried about her trial in January and her relationship with Prisoner A. A prison GP prescribed mirtazapine, an anti-depressant. Ms Mellor retained regular contact with her case worker. She said that she could not handle being separated from Prisoner A and that, if this happened, her ‘head will go’. The ACCT was closed at the end of October.

30. An ACCT was opened again a week later after Ms Mellor cut her arm again. She said she was upset because she had been told Prisoner A could not live on the same spur of the wing because of concerns raised by her offender manager (probation officer) about their relationship. She cut her arm again a couple of weeks later.

31. In January 2018, Ms Mellor told her case worker that she was struggling to believe that Prisoner A would remain with her. She said that she did not care what sentence she received as long as they were together.

32. Later that month, Ms Mellor was sentenced to 21 months for offences of violence. She was returned to Styal. At an ACCT case review, Ms Mellor was said to be

'ecstatic' as she had only had five and a half months to serve. She said she had no thoughts of self-harm and agreed that she would continue to work with the mental health team on her eating disorder. The ACCT was closed.

33. In February, Prisoner A was released to an Approved Premises (AP) with a licence condition that she should not contact Ms Mellor. On 5 April, Ms Mellor was released on Home Detention Curfew. One of her licence conditions was to live in supported accommodation provided by the Mulberry Community Project (MCP). The following day she was recalled to prison after taking cocaine at the MCP premises, being aggressive to other residents and contacting Prisoner A without permission. Ms Mellor remained unlawfully at large until the end of April, when she was arrested and returned to Styal.

34. During this period, Ms Mellor's offender manager completed an OASys report (which sets out an offender's risks and needs). This referred to a letter to Prisoner A, in which Ms Mellor said that she could not live without her. Ms Mellor had previously told her offender manager that she only had Prisoner A for support as she did not have contact with her own family. Her offender manager wrote that this indicated 'a level of fixation on the relationship, and a high level of dependency on Prisoner A'. The report concluded that if Ms Mellor's relationship with Prisoner A broke down, her risk of serious self-harm could increase.

HMP Styal – 28 April to 4 June 2018

35. When she returned to Styal, Ms Mellor was assessed by a nurse. She told the nurse that she had 'ligatured' two weeks previously in the community because she was 'stressed'. The nurse wrote in Ms Mellor's clinical record that her presentation was normal, and that she did not have current suicidal thoughts or thoughts of deliberate self-harm. She noted her history of depression and anxiety. Ms Mellor tested positive for cocaine, benzodiazepine and opiates and said that she had been spending £100- £200 a day on heroin. The nurse prescribed methadone to support her drug withdrawal.

36. The case worker, who had established a rapport with Ms Mellor during her previous stay at Styal, went to see her in the first night centre on the day she arrived. However, as Ms Mellor was detoxing, she asked to see the case worker another time. On 1 May, Ms Mellor's case was discussed at the mental health team allocations meeting and she was formally allocated to the case worker's caseload.

37. On 6 May, Ms Mellor completed a five-day review of her detoxification treatment with a Healthcare Support Worker. Ms Mellor said that she was currently on 30mls of methadone and wanted to begin a reduction prior to release. On 7 May, Ms Mellor's methadone prescription began reducing by 5mls weekly.

38. On 11 May, Ms Mellor did not turn up for her first appointment with her case worker. She went to the healthcare unit and said that she had forgotten about her appointment and asked for another date. She was given a rescheduled appointment for 23 May.

39. In May, Ms Mellor's offender manager, who had previously advised that Ms Mellor and Prisoner A should not be on the same residential unit, agreed with prison managers that Ms Mellor might benefit from having her partner's support. On 22

May, they both moved to Wilson House, one of the residential units, where they shared a room with two other women.

40. Prisoner A told the investigator that after she and Ms Mellor returned to Styal in April, their relationship was going well, although Ms Mellor was sleeping more and appeared anxious, which she thought might be because of their different release dates. She thought Ms Mellor's mood was low, but she said she did not speak to officers about it as Ms Mellor had a GP appointment and she thought her medication would be sorted out then.

41. On 23 May, Ms Mellor did not attend her mental health appointment with her case worker. The case worker told the clinical reviewer that she was not particularly worried by this because Ms Mellor would always contact her if she wanted another appointment and that they engaged well. She did not think Ms Mellor was trying to avoid her. Another appointment was made for 7 June.

42. Prisoner A told the investigator that she thought Ms Mellor did not attend her appointments with the case worker because she did not like 'opening up' and simply wanted to see the GP and get antidepressants.

Events of 4 June

43. On the morning of 4 June, Ms Mellor saw a prison GP. Ms Mellor said that she had mixed anxiety and depressive disorder and had tried several types of anti-depressants, but that trazadone had helped in the past. The GP wrote in Ms Mellor's clinical record that she had mental health input, difficulty sleeping, previous bulimia, no motivation, was tearful, and had no suicidal ideation. She requested blood tests to exclude physiological causes, prescribed trazodone and said that she would see Ms Mellor in two weeks for a review.

44. Prisoner A told the investigator that she saw Ms Mellor's name on a 'debt list' belonging to another prisoner. This meant that Ms Mellor had obtained drugs and owed them a payment (although she said she later discovered this was not the case). Prisoner A was angry because they were both trying to keep off drugs and were detoxing with methadone. She said she had not seen Ms Mellor taking drugs in Styal and had not seen her under the influence or suspected she was taking anything.

45. At about 3.00pm, Prisoner A confronted Ms Mellor about her drug use, and they had a heated argument. Ms Mellor was very angry and grabbed Prisoner A's face. Prisoner A told the investigator that she had never seen Ms Mellor so angry, and she was afraid of making a scene and attracting the attention of officers. Ms Mellor grabbed their shared room key from her and said, "This will be on your head". Another prisoner who was working nearby said she heard Ms Mellor say, "Watch what I do now, and it's on your fucking head". Ms Mellor walked off towards Wilson House and Prisoner A let her go as she thought she had gone to calm down.

46. An officer told the investigator that she was patrolling the grounds that afternoon when Ms Mellor asked her to let her into Wilson House because she had finished work for the day. She said Ms Mellor did not seem upset or show any behaviour that made her concerned for her wellbeing. She unlocked the door to Wilson House and Ms Mellor went in.

47. Prisoner B, who was friends with Ms Mellor, told the investigator that she had walked around the prison grounds with Ms Mellor that morning. She said Ms Mellor had seemed a little down. In the afternoon, she saw Ms Mellor and Prisoner A having an argument. She said that although both were upset and crying, it did not appear to be particularly serious. When she saw Ms Mellor grab Prisoner A's face, she was concerned that they might get into trouble, so she told them to stop, and Ms Mellor walked off.

48. Prisoner B told the investigator that Prisoner A said Ms Mellor had said she was going to kill herself (though Ms Hickey denies this). A few women had gathered around and were saying Ms Mellor would not kill herself. Prisoner B said she would check on Ms Mellor and walked to Wilson House. As the front door was locked, she shouted Ms Mellor's name until she appeared at the window of her room. She said Ms Mellor was crying a lot and seemed a bit hysterical. She was doing something with her hands. Prisoner B talked to her at the window for a few minutes and then went to get Prisoner A, as she felt something was not right. They returned a couple of minutes later and shouted for Ms Mellor to come to the window, but she did not appear.

49. Prisoner C said that she was in Room 6 of Wilson House at about 3.00pm, with her door open, when she saw Ms Mellor walk past, go into Room 4 and close the door behind her. About five minutes later, she heard shouting outside the building and when she looked through the window, Prisoner A (who was with Prisoner B) asked her to check on Ms Mellor. She described Prisoner A as panicking and seeming upset. Prisoner C tried to open Ms Mellor's room door, but it was locked. She looked through the window in the door but there did not seem to be anyone in the room and all four bunk beds looked unoccupied. She and a prisoner in the room next door shouted to Ms Mellor, but there was no reply.

50. Prisoner A saw two officers through an open window in an office in Gordon House and asked one of them to let her in to Wilson House. Officer A said in her police statement that she did not get the impression it seemed urgent. Officer B walked Prisoner A to Wilson House, which was a couple of minutes away. Prisoner A told her that Ms Mellor was not answering when they called. Officer B opened Ms Mellor's room door and, as she walked in, she saw Ms Mellor suspended by a dressing gown belt from the bunk bed ladder.

51. At 3.44pm, Officer B radioed for an ambulance to be called immediately to Wilson House. She did not use an emergency code blue, indicating that a prisoner is having breathing difficulties or is unresponsive. Other officers told the investigator that they ran immediately to Wilson House because the officer sounded distressed, and they assumed something serious had happened.

52. Officer B cut the dressing gown sash from around Ms Mellor's neck using her anti-ligature knife and Ms Mellor fell to the floor, injuring her nose. Officer A was also present but was too shocked to be able to help. Other officers arrived and escorted the first two officers out of the room. An officer arrived and took Prisoner A away from the scene.

53. A nurse responded to the radio call for assistance. She saw Ms Mellor lying on the floor, with vomit on her clothes and the floor. She applied defibrillator pads, but a

shock not was not recommended, so she began chest compressions. A Matron and another nurse helped until paramedics arrived.

54. Northwest Ambulance Service's first responder arrived at 3.52pm and an ambulance at 3.57pm. At 4.09pm, paramedics found a slight pulse and at 4.30pm, Ms Mellor was put into an ambulance and left the prison at 4.45pm. She was accompanied by two officers and a senior manager.

55. A hand-written note from Ms Mellor was found on a pillow in her room. It said, 'All I've ever done is love you and I always will forever and always. I mean that, love Mushy Pea xxx.'

56. At 7.00pm, Prisoner A arrived at the hospital, accompanied by two officers.

57. Ms Mellor's condition deteriorated, and she died at 10.30pm.

Contact with Ms Mellor's family

58. A senior manager appointed two family liaison officers. Ms Mellor had named Prisoner A as her next of kin. They arranged for her to be escorted to Wythenshawe Hospital.

59. They also called Ms Mellor's father's telephone number, but there was no answer. Cheshire police sought assistance from Staffordshire police, who located Ms Mellor's father. He was informed of his daughter's death in person by the police and this was followed up by visits from Styal's family liaison officers to both her parents.

Support for prisoners and staff

60. The residents of Wilson House were taken to the safer custody centre and supported by Listeners and staff. The residents spoke about Ms Mellor and Prisoner A's relationship, that they had argued, and Ms Mellor was heard to say she would not be in Prisoner A's life anymore. They said Ms Mellor had been 'up and down' and had seen the GP that day for anti-depressant medication.

61. The prison posted notices informing other prisoners of Ms Mellor'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 Ms Mellor's death.

62. At 5.10pm, staff had a hot debrief led by a senior manager, where they talked about what had happened and received support from members of the care team.

Information received after Ms Mellor's death

63. Prisoner B told the investigator that she had had a couple of conversations with Ms Mellor the week before Ms Mellor's death. Ms Mellor said she felt a bit low because she would be released soon without Prisoner A (who was due to be released a few weeks later). She said that Prisoner A was Ms Mellor's 'absolute life'. She said Ms Mellor said she would like to come back to jail after her release so she could be with

her again as she had no one else in the community. She also said she did not believe Ms Mellor was taking drugs.

64. Prisoner C said Ms Mellor was upset that healthcare staff did not give her medication for depression on the day she arrived. She said Ms Mellor was taking illicit drugs to help her sleep, and she had seen her take them twice, the last time was a couple of days before she died. She did not know what they were but thought it might have been quetiapine (an antipsychotic drug). She had not disclosed this to anyone before. She also said she thought Ms Mellor might have been worried that another prisoner wanted a relationship with Prisoner A.

Post-mortem report

65. The post-mortem report gave Ms Mellor's cause of death as hypoxic ischaemic brain injury (a lack of oxygen to the brain) caused by compression to the neck due to hanging.

66. Toxicology tests showed therapeutic levels of methadone, trazadone, mirtazapine, and olanzapine (an antipsychotic) in Ms Mellor's system when she died. Ms Mellor was prescribed methadone and had been prescribed trazadone that morning but was not prescribed mirtazapine or olanzapine.

Findings

Assessment of risk

67. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. We have, therefore, considered whether staff should have identified that Ms Mellor was at risk before her death.

68. Ms Mellor had a history of depression and self-harm and had been managed appropriately under ACCT procedures after cutting herself during previous periods in prison when she said she was worried about her relationship with her partner.

69. Ms Mellor's offender manager was concerned that Ms Mellor was very dependent on her partner and in April 2018, she warned that Ms Mellor would be at risk of serious self-harm if their relationship ended. Ms Mellor confided to a friend that she was worried about being released from prison alone, before her partner. Another prisoner thought Ms Mellor may have been worried about their relationship.

70. On the day of her death, Ms Mellor asked a GP for an anti-depressant saying she lacked motivation and had difficulty sleeping, but she did not mention her concerns about her partner. Nor did she tell the officer who let her back into Wilson House that she had argued with her partner and wanted to harm herself.

71. We are satisfied that in the days leading to her death, there was nothing to indicate to staff that Ms Mellor was at increased risk. We consider that it would have been difficult for staff to have foreseen her death.

Emergency Response

72. The officer who found Ms Mellor unresponsive in her room radioed for assistance and an ambulance but did not use a medical emergency response code in line with Prison Service Instruction 03/2013. In practice this did not cause a delay as several staff responded immediately to her request because of her distressed tone. There was no delay before an ambulance was called and CPR was initiated quickly. However, it is important that staff use the appropriate emergency codes and, not doing so, may cause delays in other medical emergencies.

    The Governor should remind all staff that they should use the appropriate emergency medical code to communicate the nature of the emergency efficiently.

Clinical care

73. The clinical reviewer concluded that the clinical care Ms Mellor received at Styal was equivalent to that which she could have expected to receive in the community.

74. The clinical reviewer noted that Ms Mellor had a positive therapeutic relationship with her case worker, and that there was evidence of person-centred care in terms

of treatment with both antidepressants and emotional support in line with her overall mental state, her previous addictions, and her eating disorder.

75. The clinical reviewer was also satisfied that Ms Mellor's substance misuse care was appropriate in terms of methadone withdrawal and, again, there was evidence of person-centred care and appropriate education on harm minimisation. Ms Mellor was offered further support by the Drug and Alcohol Recovery Service, but she declined.

76. We make no recommendation.

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