Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Russell Trelore, a prisoner at HMP Buckley Hall, on 27 May 2025

A report by the Prisons and Probation Ombudsman

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

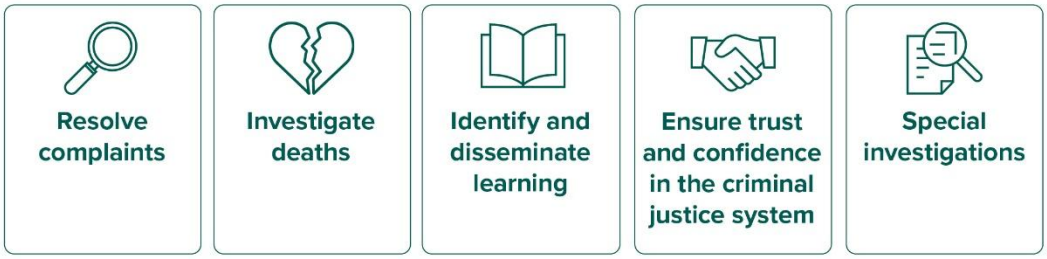
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In 2011, Mr Russell Trelore was sentenced to life imprisonment with a minimum time he had to spend in prison of sixteen years for murder. He died in hospital of pulmonary thromboembolism (when a blood vessel in the lungs gets blocked by a blood clot) on 27 May 2025, while a prisoner at HMP Buckley Hall. Fatty liver disease also contributed to his death. He was 64 years old. We offer our condolences to Mr Trelore's family and friends

4. The Ombudsman's office wrote to Mr Trelore's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Trelore's clinical care at HMP Buckley Hall. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Trelore received at Buckley Hall was of a good standard and equivalent to that which he could have expected to receive in the community. She found that although Mr Trelore had limited contact with healthcare staff during his time at Buckley Hall, he was consistently seen in a timely manner when required, and his healthcare needs were appropriately met. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Trelore's care.

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

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

   Mr Trelore's family received a copy of the draft report. They did not make any comments.

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

Inquest

10. At the inquest held on 24 December 2025, the Coroner concluded that Mr Trelore died from natural causes.

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