Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Mellor a prisoner at HMP Leeds on 11 July 2019

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
F I 020 7633 4141

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*

Summary

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

3. Mr Robert Mellor, who was 59 years old, died in hospital on 11 July 2019 of leukaemia, while a prisoner at HMP Leeds. We offer our condolences to Mr Mellor's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Mellor received was of a good standard, and equivalent to that which he could have expected to receive in the community. She made no recommendations.

5. We are concerned that Mr Mellor continued to be restrained in hospital up to 3 July, despite a decision having been taken on 1 July that restraints should be removed. The decision taken on 1 July was never communicated to the escorting staff at the hospital, which resulted in Mr Mellor being restrained unnecessarily for two days.

Recommendations

- The Governor should ensure that decisions to remove or reduce the level of restraints are communicated immediately to bedwatch staff.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Mellor's clinical care at HMP Leeds. The clinical review is attached to this report as Annex 1.

7. The PPO has investigated the non-clinical issues in Mr Mellor's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. One of our family liaison officers wrote to Mr Mellor's next of kin, to explain the investigation. She did not respond.

9. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Previous deaths at Leeds

10. Mr Mellor was the 18th prisoner to die at HMP Leeds since July 2017. Of the previous deaths, seven were from natural causes, eight were self-inflicted, one was drug-related and one was a homicide.

Key Events

11. In March 2019, Mr Robert Mellor was sentenced to 33 months in prison for grievous bodily harm. He was sent to HMP Leeds.

12. On 12 June, Mr Mellor saw the prison doctor because he was feeling unwell. The doctor arranged for him to be taken to hospital for further tests. On 14 June, Mr Mellor was diagnosed with leukaemia. He was told of the diagnosis and his next of kin were informed. He remained in hospital.

13. On 21 June, Mr Mellor started chemotherapy, however, this was soon stopped because he was too unwell. The consultant said that Mr Mellor should have palliative care only.

14. On 5 July, the prison started the process for early release on compassionate grounds. Unfortunately, Mr Mellor died before this process had been completed.

15. Staff had planned for Mr Mellor to be transferred to Kirkwood Hospice on 8 July, for end of life care. However, he was too unwell to travel and on 11 July at 4.10am, he died in hospital.

16. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital doctor. The doctor gave the cause of death as lymphoblastic leukaemia.

Non-Clinical Findings

Restraints

17. When Mr Mellor was taken to hospital on 12 June, he was restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

18. On 1 July, Mr Mellor's health deteriorated so a prison manager decided that restraints should be removed. However, this decision was not communicated to the bedwatch staff at the hospital so restraints remained in place.

19. On 3 July, nursing staff asked for Mr Mellor's restraints to be removed because Mr Mellor was very unwell. The bedwatch staff contacted a manager at the prison who agreed to the removal of restraints. Because of poor communication between prison staff and bedwatch staff, Mr Mellor was restrained unnecessarily for two days. Therefore, we make the following recommendation:

    The Governor should ensure that decisions to remove or reduce the level of restraints are communicated immediately to bedwatch staff.

Louise Richards **September 2019**
Assistant Ombudsman