

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Thomas McEllin,
a prisoner at HMP Leyhill,
on 1 September 2020**

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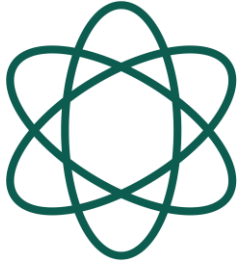
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Our vision

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

OGI

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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 Thomas McEllin died in hospital on 1 September 2020 of aspiration pneumonia (caused by a stroke) while a prisoner at HMP Leyhill. Mr McEllin was 72 years old.
4. The clinical reviewer considers that the care provided to Mr McEllin was of a reasonable standard and equivalent to that which he could have expected to receive in the wider community. He made recommendations about reviewing and recording prisoner's medication compliance, which the Head of Healthcare will want to address.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr McEllin's clinical care at HMP Leyhill.
7. The PPO investigator has investigated non-clinical issues, including Mr McEllin's location, the security arrangements for his hospital escorts, and whether compassionate release was considered.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Leyhill

9. Mr McEllin was the sixth prisoner to die at HMP Leyhill since September 2018. All six deaths were from natural causes. There are no similarities between our findings in the investigation into Mr McEllin's death and our investigation findings for the previous deaths.

Key Events

10. On 17 September 2010, Mr Thomas McEllin received an indeterminate sentence for public protection (with a minimum tariff of 30 months) for sexual assault, breach of a sex offenders' order and malicious wounding.
11. Mr McEllin spent time in a number of different prisons, before being transferred to HMP Leyhill on 16 March 2020. He was registered blind, a wheelchair user and had a history of heart disease, stroke and a heart attack.
12. On 11 May, a prison GP examined Mr McEllin for shortness of breath. Following an abnormal ECG (to check the heart's rhythm and electrical activity), she sent Mr McEllin to hospital by emergency ambulance, where a chest X-ray showed suspected lung cancer.
13. On 14 May, Mr McEllin was discharged back to prison, where a Supervising Officer (SO) spoke to Mr McEllin about his suspected diagnosis. Mr McEllin said he had no family to contact. The SO visited Mr McEllin weekly to offer support.
14. The prison applied for Mr McEllin's release on a special purpose licence due to COVID-19 on 15 June, in case he needed to 'shield' in the community (if deemed safer than staying in prison). As Mr McEllin did not have any family and there were no places at an Approved Premises due to COVID-19 restrictions, the Governor and Mr McEllin's Offender Manager did not support this application and release was not approved.
15. In June, the hospital investigated the extent of Mr McEllin's cancer, but the results were inconclusive. On 6 July, Mr McEllin told a hospital consultant that if they could not cure his cancer, he did not want life-prolonging treatment and he signed a do not resuscitate order.
16. Although the Head of Healthcare started to apply for Mr McEllin's release on compassionate grounds on 13 August, the application was not pursued as the hospital could not provide either a confirmed diagnosis or prognosis.
17. On 20 August, the hospital consultant confirmed that Mr McEllin had metastatic lung cancer with a life expectancy of months on 20 August. Mr McEllin was admitted to hospital on 23 August after an officer found him in his cell looking very weak and struggling to talk. A hospital nurse confirmed that Mr McEllin had had a stroke. The prison granted Mr McEllin Release on Temporary License (ROTL) to the hospital. He was accompanied by an officer for support purposes.
18. On 29 August, the hospital withdrew treatment and he was given pain relief. His condition continued to deteriorate, and he died on 1 September at 7.52am.
19. The Coroner concluded that Mr McEllin died of aspiration pneumonia caused by an ischaemic stroke. Lung cancer also contributed to his death.

Karen Johnson
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June 2021

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