

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marc Skelly, a prisoner at HMP Lindholme, on 22 June 2022

A report by the Prisons and Probation Ombudsman

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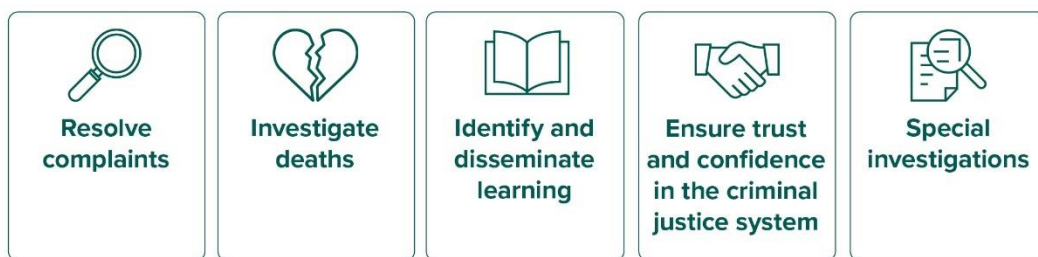
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OUR VISION

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



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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.

Mr Marc Skelly was found hanging in his cell at HMP Lindholme on 16 June. He died in hospital on 22 June. He was 33 years old. I offer my condolences to his family and friends.

Mr Skelly had a number of risk factors which indicated that he was at risk of suicide and self-harm. He often told staff that he felt unsafe in prison. Mr Skelly was monitored under suicide and self-harm prevention measures (known as ACCT) for the majority of his time at Lindholme. We found some deficiencies in the way ACCT procedures were managed.

The clinical reviewer concluded that the care Mr Skelly received for his substance misuse and mental health was not equivalent to that which he could have expected to receive in the community.

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
Prisons and Probation Ombudsman

October 2023

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	12

Summary

Events

1. In August 2021, Mr Marc Skelly was remanded into custody, charged with robbery. He was sentenced to eight years in prison in November and was sent to HMP Lindholme in February 2022.
2. Mr Skelly had a history of self-harm, mental illness and substance misuse. He was managed under a care, support and intervention plan (CSIP) after he told prison staff that he was under threat from other prisoners and had drug-related debts.
3. On 6 February, prison staff started suicide and self-harm prevention procedures, known as ACCT, after Mr Skelly's mother telephoned the prison and expressed concern that he was suicidal. Mr Skelly was monitored under ACCT procedures for the majority of his time at Lindholme.
4. On 3 June, Mr Skelly's custodial behaviour deteriorated, and he was moved to the care and separation unit. A mental health nurse advised against Mr Skelly's segregation, and he was returned to the wing.
5. On 10 June, Mr Skelly started isolating in his cell because he believed he was under threat from other prisoners. Staff monitored Mr Skelly under the prison's self-isolation strategy.
6. At 10.59am on 16 June, an officer carrying out an ACCT check found Mr Skelly sitting on the floor, with a ligature around his neck which was attached to the toilet. Staff and paramedics resuscitated him, and he was taken to hospital. Mr Skelly did not regain consciousness and, at 5.25am on 22 June, it was confirmed that he had died.

Findings

1. The investigation found that Mr Skelly received appropriate support through a challenge, support and intervention plan (CSIP). There were a number of failings in the management of ACCT procedures. Case reviews were not always multidisciplinary and Mr Skelly's most recent caremap did not include a specific action to address his substance misuse. Prison staff did not carry out a post-closure review.
2. Mr Skelly was not seen by the substance misuse service in the weeks before his death despite his history of substance use and drug-related debt.
3. Mr Skelly had been diagnosed with personality disorders and was prescribed antidepressants and antipsychotic medication. His mental healthcare was provided primarily through the ACCT process and healthcare staff did not assess if his mental health should be addressed on an individual therapeutic basis. The clinical reviewer concluded that Mr Skelly's substance misuse and mental healthcare was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions. In particular, staff should:
 - hold multidisciplinary ACCT reviews; and
 - set effective caremap objectives which are specific, time-bound, meaningful, aimed at reducing risk and updated at each case review.
 - The Governor should ensure that ACCT post-closure reviews are conducted in line with Prison Service instructions and should be held to check the prisoner's progress and to decide whether further monitoring is needed.
- The Head of Healthcare should ensure that prisoners who need mental health support receive a full mental health assessment to determine if they need individual therapeutic intervention.
- The Head of Healthcare should ensure that the substance misuse team considers a prisoner's substance misuse history and custodial behaviour when assessing the required level of substance misuse support.

The Investigation Process

4. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
5. The investigator obtained copies of relevant extracts from Mr Skelly's prison and medical records.
6. NHS England commissioned a clinical reviewer to review Mr Skelly's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
7. We informed HM Coroner for South Yorkshire East District of the investigation. We had not received a copy of the post-mortem examination at the time of writing this report. We have sent the Coroner a copy of this report.
8. We wrote to Mr Skelly's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Skelly's mother asked:
 - Why was Mr Skelly not moved to another prison after he jumped on the netting?
 - What action did staff take when Mr Skelly was in debt to other prisoners?
 - Was Mr Skelly being monitored under suicide and self-harm prevention measures?

We have answered Mr Skelly's mother's questions in this report. Mr Skelly's mother also raised other matters that we have addressed separately.
9. Mr Skelly's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Lindholme

11. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Care UK provides healthcare services, with healthcare staff on duty between 7.30am and 7.30pm every day.

HM Inspectorate of Prisons

12. The most recent inspection of HMP Lindholme took place in October 2017. Inspectors reported that levels of self-harm were higher than at similar prisons. Drug use, debt and violence were often linked to the causes of self-harm and two self-inflicted deaths had been linked to drug use.
13. Inspectors found some improvements in the care of prisoners at risk of self-harm and subject to ACCT processes. Case management was more consistent, ACCTs were quality assured and findings were discussed at the monthly safer custody meeting. Inspectors came across examples of good care for prisoners, with the most complex cases considered at weekly multidisciplinary safety meeting. However, for other prisoners, the quality of ACCT care provision was mixed, caremaps were not robust enough to address all identified issues and some reviews were not sufficiently multidisciplinary.

Independent Monitoring Board

14. 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 January 2022, the IMB reported that the number of self-harm incidents had decreased slightly in comparison to the previous year. The number of ACCT documents opened in the reporting period had also decreased. The IMB reported that 80.6% of prisoners said they felt safe, in comparison to 81.8% in October 2019.
15. The IMB was pleased to report that there were no deaths in custody during the reporting year.

Previous deaths at HMP Lindholme

16. Mr Skelly was the second prisoner to die at Lindholme since June 2020. The previous death was drug-related. There are no similarities between our findings in the investigation into Mr Skelly's death and our investigation findings for the previous death.

Assessment, Care in Custody and Teamwork

17. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The

purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

18. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
19. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011 on safer custody.

Challenge, Support and Intervention Plan

20. A challenge, support and intervention plan (CSIP) is the national case management model for managing those who are violent or pose raised risk of harming others through violent behaviour. It can also be used to support victims or potential victims of violence.
21. It aims to challenge violent behaviours and set clear expectations on what behaviours are not acceptable, making sure that punitive measures are not applied in isolation. It places equal focus on ensuring that individuals with challenging behaviours can progress towards a more positive outlook, where they choose not to reoffend.
22. CSIP should be targeted at those individuals who display more challenging violent behaviours or those who show signs they are highly likely to display this behaviour. These challenging behaviours could be identified by the nature or frequency of their violence or the extent to which their behaviour strongly indicates that they are likely to display more challenging violent behaviours. It is important that CSIP is never used in place of an ACCT plan.

Key Events

23. On 21 August 2021, Mr Marc Skelly was remanded to HMP Leeds, charged with robbery. Mr Skelly had been in prison before. On 31 November, he was found guilty and sentenced to eight years in prison. Mr Skelly had a history of attempted suicide, substance misuse, anxiety and depression and personality disorders. He was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) for the majority of his time at Leeds after cutting himself. Mr Skelly told staff that he knew other prisoners from his time in the community. He believed he was under threat from other prisoners due to his offence and was moved to a different wing on two occasions.
24. On 21 December, Mr Skelly was transferred to HMP Humber. He was managed under ACCT procedures on one occasion after he harmed himself by cutting himself.
25. On 21 January 2022, prison staff told Mr Skelly that he had been accepted at HMP Lindholme. Mr Skelly was very happy with this news and said it would make it easier for his parents to visit.

HMP Lindholme

26. On 2 February 2022, Mr Skelly was transferred to HMP Lindholme. A nurse completed his initial health screen and noted his history of depression and anxiety. Mr Skelly said that he did not have any thoughts of suicide and self-harm. The nurse prescribed him antidepressants and antipsychotic medication which he was not allowed to keep and administer himself. The nurse referred him to the prison's mental health team.
27. Prison staff completed a cell-sharing risk assessment (CRSA), which recorded that Mr Skelly posed a standard risk for sharing a cell. In line with COVID-19 restrictions, Mr Skelly was placed in isolation for ten days. A prison officer completed his first night induction interview. She noted that he had a positive attitude and had recently been monitored under ACCT procedures. Mr Skelly said that he did not have any thoughts of suicide or self-harm. He was allocated a keyworker who completed regular welfare checks. Mr Skelly told his keyworker that he was happy to be at Lindholme and he did not share any issues or concerns.
28. On 5 February, Mr Skelly threatened his cellmate because he was unhappy about having to isolate. Prison staff increased Mr Skelly's cell-sharing risk to high and moved him to a single cell.

ACCT monitoring: 6 February to 18 March

29. On 6 February, Mr Skelly's mother telephoned the prison and said that Mr Skelly had told her that he was feeling suicidal. Prison staff started ACCT monitoring and added two actions to Mr Skelly's caremap which were to continue to engage with the mental health team and substance misuse service.
30. On 9 February, Mr Skelly moved to K wing and prison staff noted that he had settled well. That day, a mental health nurse assessed Mr Skelly and diagnosed him with

anxiety, depression, borderline personality disorder, emotionally unstable personality disorder and possible dissocial personality disorder.

31. On 13 February, Mr Skelly told a prison officer during an ACCT check that he wanted to move to another wing and asked to speak to the supervising officer on the wing. The prison officer submitted a challenge, support and intervention plan (CSIP) referral to the safer custody team which stated that Mr Skelly did not appear to have many friends on the wing and may have debt-related problems. The safer custody team allocated a senior officer as Mr Skelly's CSIP case manager and an officer as his CSIP liaison officer.
32. That day, the CSIP liaison officer spoke to Mr Skelly in his cell. Mr Skelly said he felt unsafe on the wing because other prisoners were using PS and he had argued with another prisoner. Mr Skelly did not disclose any further details about the argument. Mr Skelly said he was not in debt, and she noted that Mr Skelly had plenty of property and canteen items in his cell to support this.
33. The CSIP liaison officer reviewed Mr Skelly's ACCT plan and noted that Mr Skelly had told his ACCT case manager that he was settled on K wing and had not raised any issues. Mr Skelly declined a referral to the substance misuse service. She advised Mr Skelly that he could access the prison's violence reduction regime and isolate in his cell. Mr Skelly said he did not want to isolate. She submitted a security information report.
34. Prison staff carried out regular ACCT case reviews with limited healthcare input. Mr Skelly initially denied being in debt to other prisoners. On 19 February, he harmed himself by cutting his arm and barricaded himself in his cell. After prison staff had removed the barricade, Mr Skelly said he was in debt to other prisoners and was unable to settle on the wing. Mr Skelly said other prisoners whom he knew before he came to prison had threatened him in his cell. During an interview with the safer custody team, Mr Skelly refused to name the prisoners involved. Prison staff submitted a security information report and increased Mr Skelly's observations to one every hour. Mr Skelly moved to G wing on 25 February.
35. Prison staff also submitted a CSIP investigation and referral form about Mr Skelly's debt. The safer custody team spoke to Mr Skelly about his debt issues and created a debt management plan and a CSIP intervention care plan the CSIP case manager noted on Mr Skelly's care plan that he would continue to receive support through ACCT monitoring, wing staff and the safer custody team.
36. On 2 March, Mr Skelly agreed to speak to a substance misuse support worker. Mr Skelly said he had used PS, pregabalin and tramadol on the wing. A nurse from the substance misuse service created a substance misuse care plan. Mr Skelly continued to use illicit substances.
37. On 12 March, prison staff agreed to stop ACCT monitoring. Mr Skelly's risk of suicide and self-harm was assessed as low, and staff noted he was receiving support from the safer custody team to ensure he did not incur further debt.
38. On 17 March, prison staff started ACCT monitoring again after Mr Skelly climbed on the railings. He told staff that he was being bullied on the wing but denied any thoughts of suicide and self-harm. Prison staff submitted an intelligence report and

submitted a CSIP referral form. Mr Skelly's ACCT case manager noted that he was being transferred to Doncaster and ACCT monitoring would continue until he had settled.

39. Mr Skelly was transferred to HMP Doncaster on 18 March and on 21 March, he attended a family court hearing. During his time at Doncaster, staff continued with ACCT procedures. Over the following weeks, staff noted that Mr Skelly's mood was low, but he said that he had no thoughts of suicide and self-harm.

HMP Lindholme: 6 April to 16 June

40. On 6 April, Mr Skelly returned to Lindholme and was allocated a cell on the reverse cohort unit on G wing. During his first night induction interview, Mr Skelly said that he had issues with other prisoners on K and G wing but refused to discuss this further. He was allocated a keyworker who completed regular welfare checks. Mr Skelly told his keyworker that he was receiving support from the mental health team.
41. A nurse completed Mr Skelly's initial health assessment and noted his history of depression and anxiety. Mr Skelly said that he did not have any thoughts of suicide and self-harm and his antidepressant prescription was continued. The nurse referred him to the mental health team.
42. On 12 April, a substance misuse service worker completed a telephone assessment with Mr Skelly. He said that he had not smoked PS or taken illicit pregabalin for eight weeks. The substance misuse service worker noted that Mr Skelly did not have any immediate substance misuse support needs. On 15 April, Mr Skelly moved to L wing, where he attended recovery support programmes to help him remain drug-free.
43. On 28 April, prison staff held a CSIP review. Mr Skelly said that he was under threat from other prisoners. That day, a substance misuse service worker noted that Mr Skelly struggled with anxiety and feeling low. Mr Skelly said that he did not have any debt issues. The substance misuse service worker noted that Mr Skelly was struggling to leave the wing to collect his medication, that he should continue to attend recovery programme groups and would be assessed again on 28 July.

ACCT monitoring: 4 May to 2 June

44. On 4 May, prison staff started ACCT monitoring after Mr Skelly cut himself. Mr Skelly told an ACCT case review that he was being bullied on L wing. Prison staff added three actions to Mr Skelly's caremap which said that he should engage with the mental health team, continue to take his medication and consider a transfer to another prison. There was no caremap action to address Mr Skelly's substance misuse, even though this was recorded as a trigger for his self-harm.
45. On 12 May, Mr Skelly moved to G wing. Prison staff noted that he had settled well, had a new job and denied using illicit substances. A substance misuse service worker noted on 19 May that Mr Skelly had not used illicit substances for six weeks and knew how to seek substance misuse support. There is no evidence that the substance misuse team saw Mr Skelly again before he died.

46. On 19 May, prison staff agreed to stop ACCT monitoring. There was no healthcare input. Staff assessed Mr Skelly's risk level as low and the actions on his caremap were complete. The post-closure phase would end on 27 May. An alert to this effect was added to Mr Skelly's electronic prison record, known as NOMIS. There is no evidence that the post-closure review took place. Mr Skelly moved to J wing on 23 May.
47. On 26 and 30 May and 1 June, prison officers gave Mr Skelly an incentives and earned privileges (IEP) warning for refusing to attend work. Mr Skelly did not attend an appointment with a psychiatrist on 30 May.
48. On 2 June, Mr Skelly told a mental health nurse that he did not always collect his prescribed medication because he felt anxious waiting in the queue. The mental health nurse arranged for him to collect his medication first or last to reduce his waiting time. This significantly improved Mr Skelly's compliance with collecting his medication.

3 to 15 June

49. At around 1.52pm on 3 June, Mr Skelly accessed the safety netting for approximately twenty minutes. (Mr Skelly was subsequently found guilty at a disciplinary hearing and received a loss of privileges for 21 days.) Prison staff moved him to the Care and Separation Unit (CASU). A mental health nurse assessed Mr Skelly's health and advised against his segregation. The nurse noted that his mood was low, he felt anxious and had thoughts of suicide and self-harm. Prison staff submitted a security intelligence report and moved him back to K wing that day.
50. At 3.30pm, a Supervising Officer (SO) started ACCT monitoring. He completed the immediate action plan and assessed Mr Skelly as at medium risk of suicide and self-harm. Mr Skelly told the SO that his head 'wasn't in the right place' and that he did not want to talk. He decided Mr Skelly should be monitored four times an hour.
51. At 11.30am on 4 June, a SO completed an ACCT assessment with a nurse. Mr Skelly said that he was in debt to other prisoners and wanted a move to another prison. The SO added three actions to Mr Skelly's careplan which said that Mr Skelly should engage with the substance misuse and mental health teams and consider a transfer to another prison. Mr Skelly denied any thoughts of suicide and self-harm and said that he intended to isolate in his cell for his own safety. The reduced Mr Skelly's observations to two every hour.
52. On 6 June, the CSIP case manager carried out an ACCT case review. A SO attended and there was no healthcare input. Mr Skelly said he had decided not to isolate in his cell and did not have any feelings of suicide or self-harm. The case manager reduced Mr Skelly's observations to one every hour.
53. Mr Skelly had a meeting with his prison offender manager (POM) to discuss his sentence plan objectives. She told the investigator that Mr Skelly said he wanted to move prisons because he had issues on whichever wing he was located. He did not want to discuss the issues further and said he hoped ACCT monitoring would stop soon. She said Mr Skelly engaged well during the meeting and appeared positive and upbeat. He did not express any feelings of suicide and self-harm. She

told Mr Skelly that he could not apply for a transfer until he had been free of disciplinary action for three months.

54. On 10 June, Mr Skelly told an officer he was under threat on the wing, and he intended to isolate himself in his cell. The officer completed a CSIP investigation and referral form and community concern form to inform the safer custody team that Mr Skelly was isolating himself. The safety custody team recorded this information and allocated an officer as his liaison officer.
55. A SO carried out an ACCT case review on 14 June with a Custodial Manager (CM). There was no healthcare input. The SO noted that Mr Skelly was isolating in his cell because he felt under threat. The SO spoke to Mr Skelly about moving to another wing. Mr Skelly said he would consider moving to G wing and he had submitted a request to transfer to another prison. The SO noted Mr Skelly's requests on his ACCT document and agreed that these would be discussed at his next ACCT case review with the CSIP case manager on 21 June. Mr Skelly asked the SO to remove two belts from his cell because he wanted to harm himself to relieve stress. The SO removed the belts and increased Mr Skelly's observations to two an hour.

Events of 16 June

56. At 8.30am on 16 June, an officer noted in Mr Skelly's prison records that he had intended to stop isolating in his cell. Mr Skelly said that he wanted to mix with other prisoners. CCTV footage showed that Mr Skelly left his cell at around 9.00am and was talking to other prisoners. At around 10.03am, two prisoners went into Mr Skelly's cell and left shortly afterwards. CCTV footage shows that Mr Skelly left his cell at 10.08am and walked around the wing. Mr Skelly did not appear upset or distressed. Shortly afterwards, Mr Skelly told the prison chaplain that he felt vulnerable and wanted to go back in his cell. The prison chaplain noted in Mr Skelly's prison records that he had passed this information to an officer.
57. At around 10.20am, an officer spoke to Mr Skelly at his cell door. He said that he felt unsafe on the wing and wanted to isolate in his cell. He refused to discuss this further and said he wanted to speak to the safer custody team. She told a SO that Mr Skelly was isolating in his cell and made an entry in his ACCT plan. She also asked the liaison officer to see Mr Skelly in his cell. She locked Mr Skelly in his cell at around 10.21am.
58. Mr Skelly telephoned his sister at 10.26am. The investigator listened to the telephone call. Mr Skelly sounded upset and told his sister that he had no money. He said he had not received the £20 she had sent him. Mr Skelly's sister agreed to send another £20. Mr Skelly's account shows he received £20 on 8 June, and he bought telephone credit that day. Mr Skelly's sister told him that someone was claiming his son was not his. Mr Skelly said he was 'losing his head', felt paranoid and needed to talk to someone. He told his sister that he wanted a transfer to another prison and would call her again at 3.00pm.
59. At 10.59am, the officer went to Mr Skelly's cell to carry out an ACCT check. On her way to Mr Skelly's cell, she passed the liaison officer, who told her she would see him shortly. When the officer arrived at Mr Skelly's cell, she looked through the cell door observation panel and saw him slouched in a sitting position on the floor, with

a ligature attached to the toilet. She radioed a medical emergency code blue (indicating a prisoner is unconscious or has breathing difficulties). The control room called an ambulance immediately. She entered Mr Skelly's cell and used her fish knife to remove the ligature from his neck. A SO arrived very shortly afterwards and started cardiopulmonary resuscitation (CPR). A defibrillator was attached to Mr Skelly and did not initially detect a shockable rhythm.

60. A nurse and a healthcare assistant arrived at Mr Skelly's cell at around 11.05am and took over CPR, assisted by another nurse. The defibrillator detected a shockable rhythm. Paramedics arrived at 11.17am and took over Mr Skelly's care. They connected Mr Skelly to a portable ventilator and took him to hospital. Two prison officers escorted Mr Skelly and did not use restraints.
61. Mr Skelly remained sedated and ventilated in hospital until his family agreed to withdraw active treatment. At 5.25am on 22 June, it was confirmed that Mr Skelly had died.

Contact with Mr Skelly's family

62. The prison appointed a CM as the family liaison officer. At around 12.00pm on 16 June, she contacted Mr Skelly's mother and told her that Mr Skelly had been taken to hospital. Mr Skelly's mother visited him in hospital before he died on 22 June. The prison contributed to the cost of Mr Skelly's funeral in line with Prison Service instructions.

Support for prisoners and staff

63. After Mr Skelly's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
64. The prison posted notices informing other prisoners of Mr Skelly's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Skelly's death.

Post-mortem report

65. The post-mortem report gave Mr Skelly's cause of death as hanging. The post-mortem toxicology results did not detect any illicit substances in Mr Skelly's blood.

Findings

Management of Mr Skelly's risk of assessment of risk and self-harm

66. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Skelly had a number of these risks, including previous self-harm, poor mental health, substance misuse, personality disorders, debt and being a potential victim of bullying and violence. He was appropriately monitored under ACCT procedures for the majority of his time at Lindholme.
67. However, the overall management of ACCT procedures was not consistently in line with PSI 64/2011. Mr Skelly's ACCT case reviews were not always multidisciplinary which meant that prison and healthcare staff did not fully consider his risk factors and triggers for his self-harm.
68. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. Instructions say they should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time bound. When staff started ACCT monitoring on 4 May, Mr Skelly's caremap did not refer to his substance misuse, even though it was one of the triggers for starting ACCT monitoring. Mr Skelly had incurred drug-related debt despite denying that he was using illicit substances. We recommend:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions. In particular, staff should:

- hold multidisciplinary ACCT reviews; and
- set effective caremap objectives which are specific, time-bound, meaningful, aimed at reducing risk and updated at each case review.

Post-closure review

69. We consider that the decision to stop ACCT monitoring on 19 May was appropriate. All support actions on Mr Skelly's caremap were complete, his risk of suicide and self-harm was low, and Mr Skelly did not express any thoughts of suicide and self-harm.
70. PSI 64/11 states that after ACCT monitoring ends, a post-closure monitoring form must be completed for at least seven days to inform the post-closure review. The post-closure interview must review the caremap and the prisoner's progress since the ACCT was closed. Although prison staff continued to monitor Mr Skelly after ACCT monitoring was stopped, they did not carry out a post-closure review as they should have done. The failure to do so meant that they did not assess how Mr Skelly was coping. For example, Mr Skelly received an IEP warning on 26 May which indicated his behaviour was deteriorating and he might have been struggling

on the wing. However, prison staff missed the opportunity to consider the impact on him at a post-closure review. We recommend:

The Governor should ensure that ACCT post-closure reviews are conducted in line with Prison Service instructions and should be held to check the prisoner's progress and to decide whether further monitoring is needed.

Substance misuse and mental healthcare

71. The clinical reviewer noted that there was no documented communication between the substance misuse team and mental health team about Mr Skelly's mental state, self-harm and substance misuse. She concluded that Mr Skelly's substance misuse and mental healthcare was not equivalent to that which he could have expected to receive in the community.
72. Mr Skelly had a long history of substance misuse and was supported by the substance misuse team when he arrived at Lindholme in February. When Mr Skelly returned to Lindholme from Doncaster in April, he told a substance misuse support worker that he had not used illicit substances and it was decided that he did not need support. During a substance misuse assessment on 28 April, a substance misuse support worker noted that Mr Skelly was located on the drug recovery wing and would be reviewed again in July. Mr Skelly told a substance misuse support worker on 19 May that he had not used illicit drugs for over a month, and he did not need any support. However, this was not supported by prison intelligence which indicated that Mr Skelly was using illicit substances and was in debt to other prisoners as a result.
73. The clinical reviewer noted that while Mr Skelly was referred to the substance misuse team promptly when he returned to Lindholme, he denied recent drug use and the substance misuse team decided he did not have any immediate needs despite his recent history of substance misuse and drug-related debt.
74. Mr Skelly was diagnosed with anxiety and personality disorders. However, his mental healthcare was provided primarily through the ACCT management process. The clinical reviewer considered that in view of his history of self-harm, anxiety and fluctuating mood, healthcare should have considered addressing his mental health needs on an individual therapeutic basis, which might have provided a better sense of his mental state. We recommend:

The Head of Healthcare should ensure that prisoners who need mental health support receive a full mental health assessment to determine if they need individual therapeutic intervention.

The Head of Healthcare should ensure that the substance misuse team considers a prisoner's substance misuse history and custodial behaviour when assessing the required level of substance misuse support.

Self-seclusion strategy

75. Lindholme's Isolating Individuals Strategy (published in 2019) says that prisoners identified as self-isolating for longer than 24 hours should be referred to safer

custody and entered on the CSIP database. Prisoners who are confirmed as self-isolating should be allocated a liaison from safer custody to understand why they are isolating themselves, to seek a solution and signpost to other support.

76. Mr Skelly was first identified as self-isolating on 10 June when he told prison staff during an ACCT case review that he wanted to remain locked in his cell because he was under threat from other prisoners. A prison officer completed a community concern form and a CSIP investigation and referral form. Safety custody allocated a prison officer as Mr Skelly's safer custody liaison officer to ensure that Mr Skelly was being appropriately monitored while he was self-isolating.
77. A Senior Officer spoke to Mr Skelly to determine why he did not want to participate in the normal wing regime and to ensure Mr Skelly understood the self-isolator regime. Mr Skelly was reminded of the support available from Listeners and the Samaritans. Mr Skelly continued to receive support through ACCT monitoring and staff explored a wing move and transfer to another prison during Mr Skelly's next case review. We are satisfied that prison staff took appropriate action when Mr Skelly was identified as self-isolating. In July 2022, after Mr Skelly's death, Lindholme also introduced an isolation management record to monitor and support self-isolating prisoners.

Management of Mr Skelly's debt

78. Lindholme's safety toolkit provides instructions to staff to help improve prison safety and to reduce the level of violence and suicide and self-harm. The toolkit brings together material about safety, including strategy, learning, examples of effective practice tools and guidance. The toolkit provides specific guidance to enable staff to identify and manage prisoners who are in debt.
79. The purpose of the safety kit is to enable prison staff to understand why prisoners get into debt and what can be done to assist prisoners who have debt-related problems. It goes on to say that prisoners identified as being in debt should be offered support through a debt management plan to explore strategies to reduce debt and to prevent them from incurring further debt. Mr Skelly often denied to other prisoners that he was in debt. He told staff that he was being threatened and prison staff established that this was related to debt. When Mr Skelly told prison staff he was in debt, they arranged for him to move wings and provided appropriate support through a debt management plan. Prison staff also submitted a CSIP investigation and referral form to inform the safer custody team. Mr Skelly's debt management plan identified that the possible triggers for his debt were substance misuse and his relationship with other prisoners whom he knew from the community.
80. After an initial period of settled behaviour, prison staff received security intelligence that indicated that Mr Skelly was in debt again. Despite their best efforts, Mr Skelly remained in debt to other prisoners for the majority of his time at Lindholme. We are satisfied that Lindholme has an appropriate strategy to manage and support prisoners who are in debt and that prison staff supported Mr Skelly to prevent him incurring further debt.

Inquest

81. At the inquest held on 6 December 2023, the Coroner concluded that Mr Skelly died by misadventure.

**Prisons &
Probation**

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