

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Lewis Skelton on 23 September 2022, following his release from HMP Durham**

**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



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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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.
3. 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.
4. Mr Lewis Skelton died from the toxic effects of a combination of prescription and illicit drugs on 23 September 2022 following his release from HMP Durham the day before. He was 24 years old. I offer my condolences to those who knew him.
5. We found that Mr Skelton received good support with his substance misuse issues at Durham. Substance misuse support was also put in place for when he was released from prison.
6. Mr Skelton was released homeless. However, we found that his community offender manager had completed the appropriate accommodation referrals to local authorities and housing agencies. The provision of suitable accommodation for people leaving prison is an issue that extends beyond the remit of Durham or local probation services, and the local authority may want to be aware of the issues raised in this case.
7. We make no recommendations.

## The Investigation Process

8. HMPPS notified us of Mr Skelton's death on 29 September 2022.
9. The PPO investigator obtained copies of relevant extracts from Mr Skelton's prison and probation records.
10. We informed HM Coroner for Durham of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
11. The Ombudsman's family liaison officer contacted Mr Skelton's next of kin, his aunt, to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of the report.
12. Mr Skelton's aunt received a copy of the initial report. She raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Durham

14. HMP Durham is a category B reception prison which holds up to 980 adult and young men who have either been convicted or are on remand. The physical health treatment provider is Spectrum Community Health CIC, and the substance misuse treatment provider is Humankind.

### HM Inspectorate of Prisons

15. The most recent inspection of HMP Durham was in November 2021. Inspectors reported that despite some gaps in clinical staffing due to recruitment difficulties, prisoners were receiving good care. Patients leaving the prison were offered harm minimisation advice and naloxone (treatment to reverse the effects of opiate overdose) training and supplies, as necessary. When patients transferred to another prison or were released into the community, services liaised to make sure there was effective discharge planning.

### Probation Service

16. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

### HM Inspectorate of Probation

17. The most recent inspection of the effectiveness of probation work in Durham was in August 2016. Inspectors found that responsible officers were experienced and competent, and their risk of harm assessments and risk management plans were overall good enough. The work delivered by responsible officers, contracted providers and partner agencies to minimise the individual's risk of harm to others was in most cases sufficient. In most cases, sufficient progress was made in delivering the requirements of the order or licence, but absences were not always responded to appropriately. While half the offenders had not sufficiently abided by their sentence or licence, the majority of these had enforcement action appropriately taken against them.

## Key Events

18. On 5 May 2022, Mr Lewis Skelton was convicted of stealing and was sentenced to 20 weeks in prison. He was sent to HMP Durham.
19. Mr Skelton was a drug user. When he arrived at Durham, a GP diagnosed him as having multiple drug dependencies and prescribed him a methadone detoxification programme (opioid medication used to treat the symptoms of heroin withdrawal). The GP referred him to the drug and alcohol recovery team (DART).
20. On 6 May, a DART recovery worker saw Mr Skelton for his induction. The recovery worker warned Mr Skelton of the risks associated with psychoactive substances and benzodiazepines (sedative medication that is widely abused). He also told Mr Skelton about naloxone (a medication that can rapidly reverse the effects of an overdose of heroin or other opioids). Mr Skelton agreed to be released with a supply of naloxone, and he was given instructions on how to administer it, in the event of an overdose.
21. On 13 May, Mr Skelton was moved to HMP Holme House, where he continued his methadone detoxification programme.
22. The next day, a healthcare assistant at Holme House saw Mr Skelton. She warned him of the risks of misusing substances while on his methadone programme. They also discussed the risks associated with using illegal drugs, including the risks of overdosing on release due to a reduction in his tolerance levels.
23. On 12 July, a substance misuse worker saw Mr Skelton for a pre-release appointment. They discussed the risks associated with taking illegal drugs and again, discussed tolerance levels and the risks of overdosing. Mr Skelton's care was transferred to the community substance misuse service (SMS), We Are With You, who would continue to issue his methadone in the community.
24. On 13 July, Mr Skelton was released from Holme House on licence. He was given a naloxone kit and instructions on how to use it.

## Recall to prison

25. After his release from prison, Mr Skelton was arrested for committing further offences. He had also stopped attending the community SMS service to collect his methadone and had returned to misusing drugs. As his community offender manager (COM) did not consider that Mr Skelton could be managed safely in the community, she revoked his licence and initiated his recall back to prison. A warrant was issued for his arrest.
26. On 29 July, Mr Skelton was arrested by police and returned to HMP Durham. In his reception interview, Mr Skelton told a nurse that he stopped taking his methadone seven days before. The nurse referred him to the GP at Durham for an assessment.

## Substance misuse

27. On 30 July, a DART worker saw Mr Skelton for an assessment. He issued Mr Skelton with another methadone prescription.
28. On 4 August, a DART worker saw Mr Skelton for a review. She agreed to increase his methadone dose to help ease his withdrawal symptoms. She warned Mr Skelton of the risks of misusing substances while on methadone.
29. On 18 August, a DART worker saw Mr Skelton for a review. As he was still experiencing withdrawal symptoms, she again increased his methadone dose. They discussed the risks associated with using illegal drugs, including the risks of overdosing on release.

## Accommodation

30. On 29 June, Mr Skelton's COM submitted a duty to refer application (DTR - where certain public authorities must notify local authorities that a person who has engaged with them might be homeless or at risk of homelessness).
31. On 23 August, Mr Skelton's COM made an accommodation referral to Commissioned Rehabilitative Services (CRS). (Various services, including accommodation, are delivered in the community by CRS providers.)
32. Mr Skelton was not offered accommodation for his release. Due to his behaviour in previous properties, neither social housing nor private landlords were willing to house Mr Skelton. The COM told the investigator that Mr Skelton's family also refused to house him following his recall to prison. As a result, Mr Skelton was released homeless.

## Release from HMP Durham

33. On 22 September, Mr Skelton did not attend his release appointment with the nurse at Durham. Healthcare staff emailed the details of his methadone prescription to his community SMS service, We Are With You, so that he was able to collect his methadone the next day. Mr Skelton was released from Durham with a naloxone kit.
34. On the day of his release, Mr Skelton failed to attend his induction appointment at Southbank Probation Office. The COM had arranged for another probation practitioner to cover Mr Skelton's case while she was on leave. They tried to contact Mr Skelton but the number that she had for him did not connect. She emailed several other agencies working with Mr Skelton and asked them to contact her, should they have any contact with him. She issued Mr Skelton with a warning letter for missing his appointment and gave him another appointment for 29 September. As Mr Skelton was homeless, the warning letter was left in the reception of Southbank Probation Office for him to collect.

## Circumstances of Mr Skelton's death

35. On the day of his release, Mr Skelton went to a friend's address where they both drank alcohol and took drugs. The next day at approximately 8.00am, Mr Skelton's

friend saw Mr Skelton coughing and vomiting up blood before becoming unresponsive. The friend gave Mr Skelton chest compressions and called for an ambulance. Paramedics attended and continued to give chest compressions for a further 20 minutes. Unfortunately, their resuscitation attempts were unsuccessful and, at 8.27am, paramedics pronounced that Mr Skelton had died.

36. On 26 September, as concerns grew for Mr Skelton's welfare, the covering probation practitioner contacted the police to ask if they had had any contact with him. The police informed them that Mr Skelton had died.

### **Post-mortem report**

37. The post-mortem report concluded that Mr Skelton died of the effects of a combination of pregabalin (a prescription medication that is widely abused as it enhances the euphoric effects of opioids), alprazolam and bromazolam (both benzodiazepines), methadone and cocaine.

## Findings

### Substance misuse

38. Mr Skelton had a history of substance misuse. While he was in prison, he was seen regularly by the DART team and warned about the risks and dangers of taking drugs. He was also trained in the use of naloxone and was released with a supply of it. We are satisfied that both the prison and probation services did all they could to manage the risks associated with Mr Skelton's substance misuse.

### Accommodation

39. Homelessness on release from prison is a significant and complex challenge. While prison and probation staff can submit referrals to local authorities and charities, there are occasions when beds are not available, or the individual does not meet the eligibility criteria for housing. This means that these individuals are released homeless and are expected to report to the local authority on the day of their release in the hope of receiving emergency housing. If an individual is homeless, it can increase the likelihood that they will commit further crimes or seek shelter and support in harmful places.
40. We consider that Mr Skelton's COM suitably prepared for his release by promptly completing accommodation referrals to the local authorities and housing agencies. The provision of suitable accommodation for people leaving prison is an issue that extends beyond the remit of Durham and local probation services, and the local authority may want to be aware of the issues raised in this case.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**January 2024**

### Inquest

The inquest, held on 24 September 2024, concluded that Mr Skelton's death was drug related.

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