

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Timothy Shaw a prisoner at HMP Chelmsford on 2 March 2017

**A report by the Prisons and Probation Ombudsman**

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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*



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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.

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

Mr Timothy Shaw was found unresponsive in his cell at HMP Chelmsford on 28 February 2017 and died in hospital two days later. The post-mortem concluded that he died from a brain injury, resulting from a drugs overdose. He was 34 years old. We offer our condolences to Mr Shaw's family and friends.

Mr Shaw had a long history of substance misuse and self-harm. He was found to be under the influence of illicit substances on a number of occasions while he was at Chelmsford. We found that these incidents were not properly investigated and staff failed to adequately support Mr Shaw in addressing his substance misuse issues. We are also concerned that Mr Shaw's family was given incorrect information about his death, and that ongoing support for the family was inconsistent.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**December 2017**

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# Summary

## Events

1. On 9 January 2016, Mr Timothy Shaw was remanded to HMP Chelmsford awaiting sentence for robbery offences. Prior to his arrival at Chelmsford, he had been in hospital for two days after taking a drug overdose and being involved in a car accident following the robbery.
2. The Person Escort Record (PER – a document that sets out risk information when transferring a prisoner between court and the prison) stated that Mr Shaw had a history of suicide and self-harm, drug abuse and mental health issues. The reception officer started suicide and self-harm monitoring (ACCT procedures) and arranged for him to see the nurse. Mr Shaw asked the nurse if he could go through a drug detoxification programme but the nurse assessed that he did not meet the criteria because he had not recently used illicit opiate-based substances. The ACCT was closed the next day.
3. On 18 April, 19 April and 15 May, staff suspected Mr Shaw of being under the influence of an illicit substance.
4. On 13 June, Mr Shaw made cuts to his arm and staff started ACCT monitoring again. On 30 June, Mr Shaw was sentenced to six years' imprisonment for robbery and driving offences. He was upset at the long sentence. ACCT monitoring continued until 11 August.
5. On 23 November, Mr Shaw was suspended from his job after items that were suspected of being connected with illicit substance misuse were found in his cell. He was later reinstated in his job and no further action was taken. However, on 26 November, he told staff that he had taken an overdose of ibuprofen and paracetamol because he felt he had been unfairly treated. Staff started ACCT monitoring again, which continued until 27 November.
6. On 31 December, Mr Shaw spent over seven hours with a Listener (a prisoner trained by the Samaritans). Both appeared to be under the influence of drugs when Mr Shaw left the Listener's cell after midnight.
7. On 10 February 2017, Mr Shaw and the same Listener were found to be under the influence of drugs during association.
8. On 19 February 2017, Mr Shaw collapsed, unconscious, in the same Listener's cell. Healthcare attended and Mr Shaw recovered. He said he had collapsed because he had taken too many painkillers for toothache. Staff believed he had taken an illicit substance. Later that day, staff received an anonymous letter from a prisoner saying that Mr Shaw had collapsed because he had been smoking morphine patches belonging to another prisoner.
9. At around 9.20am on 28 February, Mr Shaw asked another prisoner to cover for him on cleaning duty as he said he needed to go to the toilet. Around 9.50am, three prisoners found Mr Shaw collapsed, unconscious, in his cell. Staff were alerted and an emergency code one (indicating that a prisoner is unconscious or having difficulty breathing) was called at 9.54am. Prison staff and healthcare

attended Mr Shaw's cell within a few minutes and started cardiopulmonary resuscitation. Paramedics arrived at 10.10am and were successful in restarting Mr Shaw's heart although he was not breathing on his own. He was taken to hospital and put on life support, but he died on 2 March.

## Findings

10. We found that Chelmsford failed to provide adequate support to Mr Shaw in addressing his substance misuse. We are concerned that staff were aware that Mr Shaw was misusing both illicit substances and prescribed medication but no action was taken. He was not tested for drugs when he was suspected of being under the influence, nor was he referred to the substance misuse team. It is not possible to say whether this would have affected the outcome.
11. Our investigation found that there were delays in Mr Shaw's offender supervisor engaging with him and finalising a sentence plan. We consider that a sentence plan may have helped to highlight substance misuse and mental health issues and to put in place the necessary support for Mr Shaw.
12. We found that the family liaison support was inadequate. Mr Shaw's family was told by an inexperienced family liaison officer (FLO) that Mr Shaw had died when he was in fact in hospital on life support. The prison then appointed another FLO to assist, but he was unable to provide ongoing support to the family at a crucial time due to staffing issues at the prison.
13. We found that there was inconsistency in the support offered to staff following Mr Shaw's death.

## Recommendations

- The Governor should ensure that:
  - there is an effective and well-implemented substance misuse strategy to reduce the availability and demand for illicit substances
  - when there is intelligence to suggest that a prisoner is in possession of illicit drugs, staff carry out a cell search and a search of the prisoner as quickly as possible and test the prisoner for drugs
  - security reporting systems are used effectively to communicate, investigate and challenge substance misuse.
- The Governor and Head of Healthcare should ensure that:
  - there is an effective strategy to reduce trading of prescribed medication
  - all prisoners who have substance misuse treatment needs are referred to the IDTS team and the referrals are properly recorded and actioned.
- The Head of Healthcare should review all prisoners using fentanyl patches and ensure (i) that those prescribing such patches are aware of the potential for their abuse in prisons and prescribe alternative medication where possible; and (ii) that, where patches are prescribed, the procedure for attaching and detaching the patches should be monitored and any discrepancy reported.

- The Governor should ensure that prisoners have early, meaningful contact with an offender supervisor and that sentence plans are completed to support the prisoner's rehabilitation during their time in custody, in accordance with PSI 19/2014.
- The Governor should ensure that:
  - all family liaison officers are aware of and follow the guidance contained in PSI 64/2011 when dealing with a bereaved family
  - there are sufficient trained family liaison officers to contact and provide effective and consistent support for bereaved families
  - appointed family liaison officers are released from their usual duties to allow them to maintain a consistent level of support to bereaved families.
- The Governor should ensure that all staff are provided with formal support from the prison following a death in custody.

## The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator visited Chelmsford on 10 March 2017. She obtained copies of relevant extracts from Mr Shaw's prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Shaw's clinical care at the prison.
17. The investigator interviewed six members of staff and one prisoner at Chelmsford. The investigator and the clinical reviewer jointly interviewed four members of healthcare staff. The interviews took place between May and June 2017.
18. We informed HM Coroner for Essex of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr Shaw's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any issues.
20. Mr Shaw's family received a copy of the initial report. They raised an issue that did not impact on the factual accuracy of this report and has been addressed through separate correspondence.

# Background Information

## HMP Chelmsford

21. HMP Chelmsford is a local prison that takes prisoners directly from courts. It holds nearly 730 men aged 18 years and older. Care UK is commissioned to provide 24-hour healthcare, which includes a range of primary care and secondary mental health services. The prison has a 12-bed inpatient unit.

## HM Inspectorate of Prisons

22. HM Inspectorate of Prisons last inspected Chelmsford in April 2016. Inspectors reported that drug availability in the prison was very high. The number of positive mandatory drug tests was higher than average and there were insufficient suspicion drug tests undertaken. Inspectors reported good local corruption prevention measures and effective links with police, but said that this was not enough to reduce the quantity of illicit drugs getting into the prison. Inspectors reported that, despite good information sharing between departments and some high quality casework, there were too few interventions to support prisoners' substance misuse needs. Many prisoners who received support for substance misuse, did not consider the support helpful. Inspectors reported that, at times, there were insufficient staff to supervise medication administration and this increased the risks of medication errors and diversion. Inspectors found that prisoners felt disengaged from offender supervisors and that assessments and sentence plans were often completed late and to a poor standard.

## Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 August 2016, the IMB had ongoing concerns about the ability of Care UK to deliver the level of service required to meet prisoners' health needs and said that the highest proportion of applications received from prisoners related to healthcare issues, including problems with medication. The Board was also concerned about the increase in the availability of drugs in the prison and how this impacted on the safety of prisoners.

## Previous deaths at HMP Chelmsford

24. Mr Shaw was the fifth prisoner to die at Chelmsford since the beginning of 2016. In one previous case, we were concerned about inadequate support for prisoners with substance misuse issues.

## Assessment, Care in Custody and Teamwork

25. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the

prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **Sentence Planning**

26. Prison Service Instruction (PSI) 19/2014 sets out the expectations for staff with regard to sentence planning. The sentence plan is the key tool for identifying what an offender will do during their sentence, based on an assessment of the factors associated with their offending, to achieve the aims of the sentence, reduce the likelihood of reoffending, promote resettlement, and reduce the risk of harm they pose to themselves and to others. The focus of sentence planning should be on achieving outcomes supported by defined actions or activity. The plan should cover the whole of the sentence and should clearly define the overall outcomes, the required activities and timescales, how the activities will be delivered, the expectations of the offender in terms of meeting the objectives, and who will have responsibility for reviewing and updating the plan during the sentence. The offender supervisor is expected to make efforts to engage the offender as an active participant in the plan as early as possible. Research evidence suggests that, if the offender feels engaged in their sentence, and the plan is drawn up collaboratively, they will be more likely to identify and take responsibility for actions they need to undertake to address their offending behaviour.

### **Mandatory Drug Testing (MDT)**

27. Prisoners are legally required to provide a sample, on request, for the purposes of drug testing. While MDT alone cannot solve the problem of drugs within prisons, it can contribute to the overall objective of reducing drug misuse when used as part of a wider and more comprehensive drug strategy. The objectives of MDT are to increase the detection of those misusing drugs, to help prisoners resist peer pressure to become involved in drug taking, to offer appropriate support to those who want to combat their drug problems, and to help identify the scale, trend, types and patterns of drug misuse in individual establishments. Prison Service Order (PSO) 3601 sets out the procedures and mandatory requirements for carrying out MDT. Target levels of between 5-15% of the prison population are expected to be randomly tested each month. Additional testing can take place if prisoners are suspected of using illicit drugs.

## Key Events

28. On 9 January 2016, Mr Timothy Shaw was remanded to HMP Chelmsford awaiting sentence for robbery offences. He had been in prison a number of times before. Prior to his arrival at Chelmsford, he had been in hospital for two days because he had taken a drug overdose and had been involved in a car accident while being pursued by police following the robbery.
29. Mr Shaw arrived at Chelmsford with a suicide and self-harm warning form and extensive risk assessment documents completed by Essex Police stating that he had been under the influence of an unknown substance at the time of his arrest. The Person Escort Record (PER – a document that sets out risk information when transferring a prisoner between court and the prison) stated that Mr Shaw had a history of suicide and self-harm, drug abuse, anxiety and depression. The PER stated that Mr Shaw had cut his throat on a prison transfer in 2014. The Criminal Justice Mental Health Team (CJMHT) assessed Mr Shaw at Court and reported that he had made threats to kill himself in prison if he was not located with his brother. The CJMHT also requested that Mr Shaw be referred to the Integrated Drug Treatment Service (IDTS).
30. At Chelmsford, the reception officer started suicide and self-harm monitoring (ACCT procedures) and recorded that Mr Shaw said he was worried about the sentence he might get. Mr Shaw said that he had not recently used heroin, but he said he had taken an overdose of heroin a few weeks before. The reception officer arranged for Mr Shaw to see a nurse.
31. Nurse A, a mental health nurse, saw Mr Shaw and noted in his medical record that he had a history of misusing illicit substances, including crack cocaine and heroin. He assessed that Mr Shaw was showing signs of withdrawing from illicit substances and referred him to IDTS for further assessment. The nurse reported no concerns about Mr Shaw's risk of suicide or self-harm and he did not consider it necessary for Mr Shaw to be referred for a mental health assessment.
32. Mr Shaw was assessed by a nurse prescriber, and a substance misuse nurse. The nurse prescriber recorded that Mr Shaw's urine samples tested positive for cocaine, cannabis and opiates. He considered that the positive reading for opiates was due to Mr Shaw receiving dihydrocodeine (opiate-based pain relief) for the injuries sustained in the car accident. The nurse prescriber recorded that Mr Shaw asked if he could go through an opiate detoxification treatment programme but he did not consider him suitable for this because he had not recently used opiate-based illicit substances. The nurse prescriber assessed Mr Shaw as suitable for ordinary location rather than the substance misuse wing, and prescribed dihydrocodeine for pain relief and mirtazapine for depression. The substance misuse nurse put an entry in Mr Shaw's medical records confirming the nurse prescriber's assessment. She also noted that she could see no signs that Mr Shaw was withdrawing from illicit substances.
33. On 10 January, Mr Shaw attended an ACCT assessment. He said he was concerned about a rival gang in the prison but said he had no thoughts of suicide or self-harm. Later that day, the first ACCT review was chaired by supervising officer (SO) A. The SO recorded that Mr Shaw was talkative and cheerful and he

was looking forward to moving to a cell with his brother. The SO had no concerns about suicide or self-harm, so he assessed Mr Shaw's risk of harm as low and stopped ACCT monitoring.

34. On 12 January, Mr Shaw moved onto B wing where he shared a cell with his brother. There followed a period of negative behaviour which resulted in loss of privileges and negative behaviour warnings, but there were no documented concerns about substance misuse. Mr Shaw began attending anxiety management sessions with Atrium counselling service. Mr Shaw was moved to A wing on 3 March, after which there was a general improvement in his behaviour and compliance with the regime. He continued to attend sessions with Atrium and there were no concerns about substance misuse.
35. On 18 April, Mr Shaw and a number of other prisoners were suspected of being under the influence of drugs and an officer submitted an Intelligence Report (IR). The report stated that Mr Shaw was also suspected of being under the influence of drugs on 19 April. Apart from staff making the dog team aware, there is no record of any further action taken as a result of this IR.
36. On 15 May, Mr Shaw was again suspected of being under the influence of drugs and received a warning. A prison officer submitted an IR. Apart from staff making the dog team aware, there is no record of any further action taken.
37. On 13 June, Mr Shaw made cuts to his arm and staff started ACCT monitoring again. At his ACCT review, he said he was unhappy on A wing as he had been labelled a "grass", he was having problems with his medication and he had not had any contact from his family. He wanted to move to another wing for a fresh start and said he wanted to start work. Mr Shaw was moved to G wing on 14 June. He settled down and started work as a wing cleaner. ACCT monitoring remained in place.
38. On 30 June, Mr Shaw was sentenced to six years' imprisonment for robbery and driving offences. An ACCT review was held the same day. Mr Shaw was tearful and worried about his long sentence but said he would not harm himself.
39. On 7 July, staff submitted an IR because they suspected Mr Shaw was taking medication from another prisoner. There is no record of any action taken in response. There is also no evidence that this information was shared with healthcare staff.
40. ACCT monitoring continued until 11 August. All caremap actions were completed and a post-closure review took place on 19 August. During this time, Mr Shaw continued to attend anxiety management sessions with Atrium counsellors. His attitude and behaviour improved significantly and he said that the ACCT had helped him through a very difficult period.
41. On 2 September, cocaine and heroin were found in another prisoner's cell and Mr Shaw told staff that he had planted the drugs there. Staff believed that Mr Shaw was being made to cover for the other prisoner under duress, and was possibly being threatened. Staff submitted an IR. Mr Shaw was referred for a violence reduction interview and contact between him and the other prisoner was stopped. No further action was taken against Mr Shaw.

42. On 13 October, staff submitted another IR because again they suspected that Mr Shaw was taking medication from another prisoner. There is no evidence to show that any action was taken as a result of this IR or that the information was shared with healthcare staff.
43. On 17 October, an IR was submitted after another prisoner had told staff that Mr Shaw was using and supplying drugs, including spice, heroin and crack cocaine. The prisoner said *"If you did an MDT on Tim you will see he needs to be stopped and removed from the wing in order to clean it up. He is not the source but everything runs through his hands. Please act."* There is no evidence that any action was taken as a result of this information until 23 November.
44. On 23 November, a security search was conducted on Mr Shaw's cell. A plastic bottle with perforations and a tin opener were found and staff considered these were unauthorised items which could be used for illicit substances. Mr Shaw was suspended from his job and had privileges removed, pending a formal adjudication hearing.
45. On 26 November, Mr Shaw told Officer A that he had taken an overdose of ibuprofen and paracetamol tablets. The officer started ACCT monitoring and Mr Shaw was assessed by healthcare. Later that day, Mr Shaw was told that no further action would be taken against him for the items found in his cell as they were shown to be authorised items. His privileges were reinstated and he was able to return to work as a cleaner.
46. At his ACCT assessment interview on 27 November, Mr Shaw told SO B that he had taken the overdose of tablets as he was upset about being suspended from his job and felt he had been unfairly treated. The SO recorded that Mr Shaw said he was feeling better now that he had his job back and that he had no intention of harming himself. Mr Shaw said that he had good family support and was also using the services of the Listeners. He said he no longer wanted to be monitored under ACCT procedures. Later that day, at the first ACCT review, SO A assessed Mr Shaw's risk of harm as low and stopped ACCT monitoring.
47. On 28 November, Mr Shaw met his new offender supervisor for the first time. The new offender supervisor recorded in his prison record that there had been a number of changes of offender supervisor, but there is no documented evidence in Mr Shaw's prison record that he had seen any other offender supervisor prior to that date. She recorded that Mr Shaw's sentence plan needed to be completed and that she hoped to do this *"within the next couple of weeks"*. She recorded that she would need to interview him again at a later date but she did not, in fact, see him again until 31 January 2017.
48. On 31 December, Mr Shaw asked to see a Listener (a prisoner trained by the Samaritans). He stayed in the Listener's cell for more than seven hours and both appeared to be under the influence of drugs when he eventually came out after midnight. Officer B submitted an IR. Officer C, a safer custody officer with responsibility for the Listener scheme, told the investigator that the security department told her what had happened and she informed the Samaritans. The Listener was initially suspended as a Listener and later permanently removed from the Listener scheme.

49. On 31 January 2017, Mr Shaw met his offender supervisor for the second time. The offender supervisor recorded that Mr Shaw had failed to attend an appointment with her on 5 January and he told her that this was because he was unable to leave the wing as he was at possible risk from another prisoner. The offender supervisor had recently refused Mr Shaw's recategorisation application (for a move to a lower category prison) and she reported that he was disappointed about this. She recorded that he was thinking of appealing the decision but wanted to wait until his sentence plan was completed. The offender supervisor said that Mr Shaw was reflective about his previous lifestyle and his victims and he became quite tearful during the interview. She said she would return at a later date to finalise his sentence plan.
50. The offender supervisor saw Mr Shaw again on 7 February. She made a detailed note in his prison record saying that Mr Shaw felt he was making good progress in custody and he spoke about wanting to have contact with his daughter. The offender supervisor again recorded that she would finalise his sentence plan and return to see him at a later date. She recorded that, shortly after their meeting, Mr Shaw had gone back to his cell and began shouting and banging doors because he was upset that someone had taken something from his cell. She recorded her concerns at witnessing this behaviour and said she felt there was still a lot of work to do with Mr Shaw to help him manage difficult situations. This was the last contact Mr Shaw had with his offender supervisor and his sentence plan was never completed.
51. On 10 February 2017, Mr Shaw and the Listener were again found to be under the influence of drugs during association. Officer D submitted an IR. There is no documented evidence that any further action was taken.
52. On 19 February 2017, Mr Shaw collapsed, unconscious, in the Listener's cell. Nurse B attended and found him to be unresponsive. She administered oxygen and Mr Shaw recovered but refused any further healthcare intervention. Nurse B said she spoke at length to Mr Shaw and told him she was concerned for him as she thought he had taken something. Mr Shaw told her he had taken three dihydrocodeine tablets as he had toothache, but she did not believe him as the Listener was also displaying similar symptoms.
53. Later that day, staff received an anonymous letter from a prisoner saying that Mr Shaw had collapsed because he had been smoking morphine patches belonging to another prisoner. Staff submitted an IR. The safer custody team told the investigator that healthcare carried out an investigation into the possible abuse of morphine patches but no details of the investigation or the outcome were recorded or provided to the investigator.
54. At around 9.20am on 28 February, Mr Shaw asked another prisoner to cover for him on cleaning duty as he said he needed to go to the toilet. Officer D told the investigator that he had last seen Mr Shaw around 9.15am and went to look for him around 9.50am when he realised that he was missing from his cleaning duty. As he started to walk towards Mr Shaw's cell, he answered a cell bell call from the Listener. While he was at the Listener's cell, another prisoner shouted to him that Mr Shaw had collapsed in his cell. The officer immediately went to Mr

Shaw's cell where three prisoners were standing by the door and Mr Shaw was lying unconscious on his bed with an ashtray close to his head.

55. Officer D radioed an emergency code one (indicating that a prisoner is unconscious or having difficulty breathing) at approximately 9.54am. He tried to rouse Mr Shaw and placed him in the recovery position. Officer E responded immediately and Officer D sent him to get the emergency bag and oxygen in preparation for the arrival of healthcare. The healthcare assistant and Nurses B, C, D and E arrived at the cell around 9.58am. Nurse B assessed that Mr Shaw had no pulse and he was not breathing so staff moved him into the corridor and started cardiopulmonary resuscitation. Paramedics arrived at around 10.10am and were successful in restarting Mr Shaw's heart, although he was not breathing on his own, and he was taken to hospital. Mr Shaw died on 2 March 2017 after life support was withdrawn with the consent of his family.

### **Contact with Mr Shaw's family**

56. On 28 February, the prison appointed SO C as the family liaison officer (FLO). She contacted Mr Shaw's mother by telephone at 11.20am to tell her that her son had been taken to hospital. SO C telephoned Mr Shaw's mother again at 1.00pm to tell her that her son had died and that he was being kept on a ventilator purely for the purposes of potential organ donation. This information was not accurate. SO C and SO A met Mr Shaw's parents at the hospital at 5.40pm and Mr Shaw's parents spoke with their son's consultant.
57. When Mr Shaw's life support was switched off on 2 March at 1.15pm, neither SO C nor SO A were present. When they arrived at the hospital shortly afterwards, Mr Shaw's parents had already left and they did not want to speak to SO C when she tried to call them.
58. The prison contributed towards the cost of Mr Shaw's funeral in line with national policy.

### **Information received after Mr Shaw's death**

59. A number of prisoners told staff that Mr Shaw was known to be taking drugs on the wing and was smoking morphine patches.
60. The Listener provided a police witness statement giving detailed information about how he and Mr Shaw had misused illicit substances together at Chelmsford. He said that Mr Shaw had used cocaine around the time of his death.
61. Staff found a syringe under Mr Shaw's bed when they were clearing out his cell.

### **Support for prisoners and staff**

62. The deputy governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The prison's care team offered support.
63. The Governor issued notices to staff and prisoners informing them of Mr Shaw's death. Officers and members of the chaplaincy team supported prisoners. Staff

reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Shaw's death.

### **Post-mortem report**

64. A post-mortem examination found the cause of Mr Shaw's death was hypoxic brain injury caused by a drug overdose. Toxicology results showed traces of benzodiazepines, opiates and cocaine in Mr Shaw's body but it was not possible to establish the levels of each drug or whether the overdose was intentional or accidental.

# Findings

## Identifying and managing Mr Shaw's substance misuse risks

65. Chelmsford's substance misuse strategy states "*Staff in HMP/YOI Chelmsford and our partner agencies will work within the resources allocated to ensure that treatment and support is available to all offenders who have identified issues relating to substance misuse and/or substance dependency to prevent and minimise both illicit drug and alcohol related harm*". It also states, "*Those identified as requiring substance misuse interventions automatically become part of the Building Futures programme and within 3 working days of arrival start a full assessment of their individual needs*". We found no evidence that staff acted in accordance with their own strategy in identifying and managing Mr Shaw's substance misuse.
66. Mr Shaw arrived at Chelmsford after having been hospitalised for a drug overdose and injuries sustained in a car accident. He had a long history of substance misuse which was recorded in his medical notes and he was known to substance misuse services both in the community and in prison. Mr Shaw said that he had taken an overdose of heroin a few weeks before, and his urine tested positive for illicit substances. He specifically asked to go onto the substance misuse wing for an opiate detoxification programme but the nurse prescriber refused this on the basis that Mr Shaw had not recently used opiates.
67. The substance misuse manager told the investigator that she felt unable to comment specifically on the assessment which concluded that Mr Shaw did not meet the criteria for detoxification, although she was present with the nurse prescriber at the time and put an entry in Mr Shaw's medical records confirming the nurse prescriber's assessment. The substance misuse manager told the investigator that it is not possible for all prisoners with opiate dependency to be offered treatment on the substance misuse wing and that some of them are referred for psychosocial treatment (the Building Futures programme) with Phoenix Futures.
68. There is no evidence to show that Mr Shaw was offered detoxification treatment or psychosocial treatment for substance misuse during his time at Chelmsford. This is concerning, given his substance misuse history and the evidence that he continued to misuse drugs in prison.
69. We found that, despite a number of occasions when Mr Shaw was suspected to be under the influence of illicit drugs, he received only one mandatory drug test (MDT) during his time at Chelmsford. This test took place in March 2016 and produced a negative result. There was significant intelligence to show that Mr Shaw was using illicit substances in the months before his death. The substance misuse strategy states, "*Offenders suspected of using drugs, based on IR, passive dog indication or other intelligence may be subject to a suspicion MDT*". We consider that there were grounds for suspicion MDTs to be carried out on Mr Shaw but this was not done. According to Chelmsford's substance misuse strategy, a positive MDT would have resulted in an automatic referral to Phoenix Futures for psychosocial support.

70. A number of Intelligence Reports (IRs) were submitted relating to Mr Shaw's drug misuse. Between April 2016 and February 2017, we found a total of 13 reports directly linking Mr Shaw to either being under the influence of an illicit substance or suspected of being involved in drug supply. On 23 November 2016, Mr Shaw's cell was searched and items were found which were initially thought to be drug paraphernalia, but this was later found to be unproven. This appears to be the only time that any direct action was taken to investigate Mr Shaw's involvement in drug supply and misuse.
71. When Mr Shaw collapsed on 19 February and a prisoner sent an anonymous letter to staff to say that Mr Shaw had been smoking morphine patches, there is no documented evidence to show that this was appropriately investigated or followed up by either the security or healthcare departments. Nurse B told the investigator and the clinical reviewer that there is no procedure in place for healthcare staff to address or follow up drug misuse in such circumstances. She said it would be for security to monitor this in terms of preventing drugs getting into the prison.
72. The clinical reviewer considered that there were missed opportunities to help Mr Shaw with his substance misuse, in particular when he was refused opiate detoxification treatment on reception to Chelmsford in January 2016.
73. The clinical reviewer was concerned that there was no pathway or protocol for following up Mr Shaw's health status or substance misuse issues when he collapsed and refused healthcare involvement after a suspected drugs overdose on 19 February 2017.
74. The clinical reviewer established that the morphine patches described by other prisoners were, in fact, fentanyl patches – opiate-based pain relief which is similar to morphine but significantly more potent. He said that these drugs are widely known to be abused by swallowing, smoking or injecting the adhesive from the patches. He recommended tighter controls on the use of fentanyl patches or consideration of an alternative form of medication due to the dangers of abuse within a prison environment.
75. We make the following recommendations:

**The Governor should ensure that:**

- **there is an effective and well-implemented substance misuse strategy to reduce the availability and demand for illicit substances**
- **when there is intelligence to suggest that a prisoner is in possession of illicit drugs, staff carry out a cell search and a search of the prisoner as quickly as possible and test the prisoner for drugs**
- **security reporting systems are used effectively to communicate, investigate and challenge substance misuse by individual prisoners.**

**The Governor and Head of Healthcare should ensure that:**

- **there is an effective strategy to reduce trading of prescribed medication**

- all prisoners who have substance misuse treatment needs are referred to the IDTS team and the referrals are properly recorded and actioned.

**The Head of Healthcare should review all prisoners using fentanyl patches and ensure (i) that those prescribing such patches are aware of the potential for their abuse in prisons and prescribe alternative medication where possible; and (ii) that, where patches are prescribed, the procedure for attaching and detaching the patches should be monitored and any discrepancy reported.**

### Sentence planning

76. Given Mr Shaw's history of substance misuse, mental health problems, self-harm and prolific offending, we are concerned that there were significant delays in agreeing his sentence plan. We consider that early, regular contact with an offender supervisor and an agreed sentence plan would have helped identify the support he needed to reduce the risks he posed. The offender supervisor said that she first met with Mr Shaw in November 2016, five months after he was sentenced. There is no evidence that he had any contact with any other offender supervisor before this time. By the time of his death on 28 February 2017, he still did not have a sentence plan. We make the following recommendation:

**The Governor should ensure that prisoners have early contact with an offender supervisor and that sentence plans are completed to support the prisoner's rehabilitation during their time in custody, in accordance with PSI 19/2014**

### Family liaison and support

77. The Safer Custody PSI 64/2011 states, "*...it is vital that accurate information about the prisoner's death is given to the next of kin. Inaccurate information given at this stage can cause unnecessary distress and suspicion and can undermine the prison's ability to build a relationship with the family.*"
78. We are concerned that the family liaison officer, SO C, telephoned Mr Shaw's mother to tell her that her son had died when, in fact, he was on life support at the hospital. SO C wrote in the family liaison log that she told Mr Shaw's mother that her son was on a ventilator purely for the purpose of possible organ donation and he would stay on the ventilator until his family had arrived to see him. We found that it was both unnecessary and inappropriate for SO C to give this detailed level of medical information to Mr Shaw's mother over the telephone. We consider that SO C's role at that stage was simply to ensure that Mr Shaw's family went to the hospital where they could be accurately informed of his condition by the relevant medical professionals.
79. SO A told the investigator that, as an experienced family liaison officer, he was asked to work alongside SO C to support her. He believed that he and SO C went on to establish a good, supportive relationship with Mr Shaw's family while they were coming to terms with the likelihood that they would have to withdraw life support. However, SO A said that he was called back to his usual duties at the prison and he was therefore unable to continue to support the family when Mr Shaw died and was unable to attend his funeral.

**The Governor should ensure that:**

- **all family liaison officers are aware of and follow the guidance contained in PSI 64/2011 when dealing with a bereaved family.**
- **there are sufficient trained family liaison officers to contact and provide effective and consistent support for bereaved families.**
- **appointed family liaison officers are released from their usual duties to allow them to maintain a consistent level of support to bereaved families.**

**Staff Support**

80. We found that there was inconsistency in the support offered to staff following Mr Shaw's death. Although most members of staff said they felt supported and knew where to go for support if they needed it, some said they were still struggling with their involvement in the incident and did not feel adequately supported. We make the following recommendation:

**The Governor should ensure that all staff are provided with formal support from the prison following a death in custody.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations