Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ashley Shaw, on 17 January 2025, following his release from HMP Fosse Way

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

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 investigated 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 Ashley Shaw died from mixed drug toxicity on 17 January 2025, the day after his release from HMP Fosse Way. He was 38 years old. We offer our condolences to those who knew him.

5. Mr Shaw had a history of substance misuse, including opiates, yet he was not offered naloxone (a medicine used to reverse the effects of an opioid overdose) prior to his release. The prison told us that local policy was to offer naloxone only to prisoners who were receiving support from the prison's substance misuse team and as Mr Shaw was not receiving support, he was not eligible for naloxone. We consider the criteria should be widened to cover all prisoners with a history of opiate use.

Recommendation

- The Head of Healthcare should work in partnership with the regional Health and Justice Leads and regional drug providers to satisfy themselves that the local policy on the offer and issue of naloxone on release captures prison leavers with previous opiate use and other relevant risk factors.

The Investigation Process

6. HMPPS notified us of Mr Shaw's death on 20 January 2025.

7. The PPO investigator obtained copies of relevant extracts from Mr Shaw's prison and probation records.

8. We informed HM Coroner for Nottingham City of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's office contacted Mr Shaw's father to explain the investigation and to ask if he had any matters he wanted us to consider. He asked why Mr Shaw was not placed in a mental health unit within the prison, and why he was deemed suitable for unsupervised accommodation on release. We have addressed these issues within our report and in a separate letter to Mr Shaw's father.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. Practice Plus Group provided an action plan which is annexed to this report.

11. We sent a copy of our initial report to Mr Shaw's father. He did not notify us of any factual inaccuracies.

Background Information

HMP Fosse Way

12. HMP Fosse Way is a category C prison resettlement prison. It is managed by Serco. Nottingham Healthcare Foundation NHS Trust provided healthcare services and substance misuse services up to 1 July 2025, when Practice Plus Group took over.

Probation Service

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

Key Events

Background

14. On 5 December 2023, Mr Ashley Shaw was sentenced to 12 weeks in prison for harassment and taken to HMP Ranby.

15. Before his release, on 18 January 2024, Mr Shaw was admitted to Herschel Prins, a secure mental health ward, under section 47 of the Mental Health Act (1983).

16. On 5 September, while at Herschel Prins, Mr Shaw was convicted of assault on a staff member and another patient. He was sentenced to 48 weeks in prison and sent to HMP Leicester. On 11 September, he was moved to HMP Fosse Way.

17. Mr Shaw had a history of mental health issues, including a diagnosis of personality disorder and schizophrenia. At the time of his sentence, he was due to be released from Herschel Prins on a Community Treatment Order (CTO). His mental health had been stable since starting monthly paliperidone injections (an antipsychotic medication).

18. Mr Shaw also had a history of substance misuse. During a previous sentence he was prescribed methadone (used to treat withdrawal from opiates such as heroin). However, he was not on any methadone at the time of his entry to Fosse Way.

Pre-release planning

Substance Misuse

19. When Mr Shaw arrived at Fosse Way, he told a nurse that he had a history of substance misuse, but said it was no longer a problem for him.

20. During his time at Fosse Way, Mr Shaw had mental health key work sessions twice a month. At each session, the nurse asked him about any issues with substance misuse. He consistently denied having any problems.

21. On 6 January 2025, Mr Shaw's community offender manager (COM) referred him to community substance misuse services. As he had a history of substance misuse, she also added a drug testing condition to his licence.

Mental Health

22. When Mr Shaw arrived at Fosse Way, staff immediately referred him to the mental health team.

23. On 9 September 2024, a nurse carried out a mental health assessment with Mr Shaw. The nurse noted that he showed no signs of self-neglect, made eye contact (though he sometimes stared), and spoke in a normal tone but mostly gave yes or no answers. The nurse found no signs of psychosis and reported that Mr Shaw was happy to continue receiving his paliperidone injection. After the assessment, the nurse referred him to a psychiatrist and assigned him a mental health nurse.

24. While at Fosse Way, Mr Shaw had twice monthly mental health key work sessions with his mental health nurse. He continued to have a monthly injection of paliperidone and did not report any problems with his medication.

25. On 25 November, Mr Shaw missed a scheduled appointment with a psychiatrist at Fosse Way. He later told his mental health nurse this was because officers had not escorted him. The nurse rebooked his appointment and gave him the new time.

26. On 18 December, a psychiatrist saw Mr Shaw for his rescheduled appointment. The psychiatrist noted that he appeared flat in mood and only spoke when prompted, but otherwise seemed well. Mr Shaw said that he used to think he was connected to rich people but no longer believed this. The psychiatrist found no signs of first-rank symptoms (a group of symptoms associated with schizophrenia) and asked the mental health nurse to follow up with community services to make sure support was in place for Mr Shaw's release.

27. On 11 January 2025, Mr Shaw's mental health nurse saw him for a key work session. She told him that upon release he would remain under the care of his local Community Mental Health Team (CMHT) and his care coordinator would stay the same. Mr Shaw said he had no concerns with his mental health, and the nurse noted that he showed no signs of relapse.

Housing

28. On 24 December 2024, Mr Shaw's COM referred him to both standard and Psychologically Informed Planned Environment (PIPE) approved premises for his release. (Approved premises provide a high level of probation supervision by staff on-site. Places are limited and are provided to individuals who pose the highest risk.) Both referrals were rejected, as Mr Shaw was assessed as only needing housing support.

29. On 5 January 2025, the COM made a referral to the local council for social housing under the Duty to Refer (requires probation staff to refer individuals who are homeless or at risk of homelessness to a local housing authority).

30. On 13 January, the COM referred Mr Shaw to the Community Accommodation Service Tier 3 (CAS3), which provides temporary housing for prison leavers. She received confirmation the same day that a property was available for him.

Release from HMP Fosse Way

31. On 16 January 2025, Mr Shaw was released from Fosse Way.

32. Mr Shaw was collected at the gate by his father. He attended the probation office on the same day for his initial appointment.

33. During the appointment, his COM explained that one of his licence conditions was to have no contact with his father until social services completed a risk assessment. This condition was in place because Mr Shaw had previously been subject to a restraining order.

34. As part of his licence conditions, Mr Shaw completed a drug test while at his probation appointment.

35. The COM then took Mr Shaw to his CAS3 accommodation. Before she left him in the accommodation, she checked with Mr Shaw that he had no thoughts of suicide or self-harm and that he felt settled. She gave him a copy of his licence and resettlement contacts, including the crisis team number for mental health. She told him that his next appointment was the following morning at 10.00am and gave him the bus route.

36. The COM was concerned that Mr Shaw presented as withdrawn and gave mostly one-word responses. She emailed Mr Shaw's prison offender manager (POM) and his community psychiatric nurse (CPN) to check whether this was his normal behaviour. Mr Shaw's key worker at Fosse Way responded to the email to say that this was usual for Mr Shaw.

Circumstances of Mr Shaw's death

37. On 17 January, Mr Shaw did not arrive for his 10.00am probation appointment.

38. Mr Shaw's father called the probation office to report that Mr Shaw's mother had visited his accommodation the night before and again that morning, but had received no response from him.

39. Mr Shaw's COM arranged to meet a housing manager at his property to gain entry. At around 1.00pm, Mr Shaw was found deceased in his accommodation by his probation officer and accommodation staff.

Post-mortem report

40. The post-mortem report concluded that Mr Shaw died from multiple drug toxicity. The toxicology report found evidence of recent use of heroin and cocaine.

Findings

Mental health

41. Mr Shaw was referred to the mental health team as soon as he arrived at Fosse Way and his mental health key worker saw him regularly throughout his time there. We consider he received a good level of support.

Housing

42. Mr Shaw's COM made the appropriate housing referrals for him and managed to secure CAS3 accommodation for his release. This accommodation was unsupervised as Mr Shaw had been assessed as needing housing support only and both applications for an AP place had been rejected.

Substance misuse

43. Mr Shaw was not offered naloxone (a medication that can rapidly reverse opioid overdose) prior to his release. The prison told us that local policy was to offer naloxone only to prisoners who are receiving support from the prison's substance misuse team. As Mr Shaw had declined support, he was not offered naloxone. We consider that Mr Shaw would have been a suitable candidate for naloxone on release given his history of opiate use. We are concerned that the provision of naloxone to prison leavers with a history of substance misuse is inconsistent across the prison estate and should be routinely offered to all prisoners with a history of opiate use. We recommend:

    The Head of Healthcare should work in partnership with the regional Health and Justice Leads and regional drug providers to satisfy themselves that the local policy on the offer and issue of naloxone on release captures prison leavers with previous opiate use and other relevant risk factors.

Adrian Usher
Prisons and Probation Ombudsman **October 2025**

Inquest

At the inquest, held on 13 August 2026, the Coroner concluded that Mr Shaw's death was drug related.

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