Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shaun Clare, on 26 December 2024, following his release from HMP Altcourse

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 Shaun Clare died from combined drug toxicity on 26 December 2024, following his release from HMP Altcourse three days earlier. He was 35 years old. We offer our condolences to those who knew him.

5. Mr Clare was a persistent offender and as a result, he was managed under the Integrated Offender Management programme (which meant he was supported by different agencies).

6. Mr Clare had a significant history of drug and alcohol misuse and because he had served a number of his sentences at Altcourse, he was well known to the staff working there. We note the challenges that the substance misuse team faces, especially when delivering interventions to prisoners who are in and out of prison on short sentences.

7. We did not identify any significant learning and we make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Clare's death on 27 December 2024.

9. The PPO investigator obtained copies of relevant extracts from Mr Clare's prison and probation records and a copy of the police incident report.

10. The investigator carried out three interviews as part of her enquiries. Transcripts of the interviews are annexed to this report.

11. We informed HM Coroner for Cheshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. The Ombudsman's office contacted Mr Clare's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any specific questions.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

14. Mr Clare's next of kin received a copy of the draft report. They did not make any comments.

Background Information

HMP Altcourse

15. HMP Altcourse is a local prison in Liverpool which receives sentenced and remanded adult male prisoners and young offenders from the Cheshire and Merseyside courts. About half the population are on remand or serving very short sentences. Sodexo took over the management of the prison in June 2023.

16. Practice Plus Group provides primary healthcare services at Altcourse. Phoenix Futures provides substance misuse services.

Probation Service

17. 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 appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Altcourse was in November 2021. At the time, inspectors reported that there was very limited provision of psychosocial support and there were also staffing shortages. However, it is worth noting that since the last report, a new provider has been appointed to provide substance misuse services.

Key Events

Background

19. Mr Shaun Clare was a prolific offender and had a significant custodial history. He was managed under the Integrated Offender Management (IOM) programme. This meant that there was multi-agency involvement, including from probation, the police and other statutory agencies in managing Mr Clare's risks and supporting his rehabilitation.

20. On 11 September 2024, Mr Clare was sentenced to ten weeks in prison for theft. He returned to HMP Altcourse, having been released from the prison less than two weeks earlier.

21. Mr Clare had a mental health diagnosis and a history of alcohol and drug use, which included heroin, cocaine and opiates.

22. Following his arrival at Altcourse, Mr Clare saw Nurse A for his initial health screen and told her that he had been drinking and using drugs in the days before he was recalled to prison. Nurse A referred him to the substance misuse service (SMS).

23. On 12 September, Mr Clare saw Mr A, an SMS worker. Mr Clare said that he was willing to engage with the SMS and received harm reduction advice. Later that day, Mr Clare started opiate substitution therapy (methadone).

24. On 17 September, Mr Clare saw Ms A, an SMS worker, and Nurse B for a five-day review. They discussed harm reduction and tolerance levels and Mr Clare received advice about alcohol consumption. Ms A recorded that Mr Clare had been trained to use naloxone (a medication to reverse the effects of opiate overdose) and they advised him to take naloxone with him when he was released.

25. Nurse B noted that Mr Clare would be homeless on release but was due to see the housing team before then. She also noted that he was working with Change, Grow, Live (CGL, an organisation which provides treatment and support to people on probation who are impacted by substance use).

26. On 18 September, an IOM case conference was held at Halton probation office. Ms A, Mr Clare's community offender manager (COM), recorded that Mr Clare was due in court again on 20 September when his sentence might be extended. It was noted that an option for housing in the Congleton area was being explored.

27. On 20 September, Mr Clare was sentenced to 16 weeks in prison for public order offences. The sentence was to run alongside the sentence he was serving.

28. On 24 September, Ms B, a senior probation officer, discussed Mr Clare with the Head of the Probation Delivery Unit. Ms B then emailed Ms A to ask her to progress several actions aimed at providing Mr Clare with significant support when he was released from prison. This included a pre-release visit, the IOM mentor taking him to places and daily contact for the first few weeks.

29. On 17 October, a pre-release IOM case conference took place. It was recorded that Mr Clare would move to the Crewe or Congleton area with Recovery Housing. It

was confirmed that he was classified as having 'red' status (which meant that he was subject to the highest level of oversight and support) because of the frequency of his re-offending.

30. On 18 October, Mr B, a worker from Emerging Futures (a support agency which provides safe homes and therapeutic support to people with complex needs), emailed Ms A to confirm that he would arrange for a colleague to collect Mr Clare from prison on 24 October.

31. On 21 October, Mr Clare was given a further prison sentence for theft and his release date was changed to 26 November.

32. On 20 November, Mr A referred Mr Clare to CGL in Macclesfield and arranged an appointment for him to meet them on 27 November.

33. On 21 November, an IOM case conference was held. It was recorded that the police would collect Mr Clare from prison and take him to his accommodation (provided by Emerging Futures). Probation staff were scheduled to visit him later that week.

34. On 26 November, Mr Clare was released from prison. Before he left, Nurse C gave him a supply of his medications. She recorded that Mr Clare refused to take naloxone and he signed a disclaimer.

35. The police collected Mr Clare and took him to CGL in Widnes, where he met his mother and Ms A. He was later taken to the job centre to claim for benefits and then to his accommodation. Mr Clare's licence required him not to commit any offences and to comply with the specified requirements to address his drug use and prolific behaviour problems.

36. On 5 December, Ms A and staff from Emerging Futures met Mr Clare at his accommodation. They discussed how he was and his recent positive drugs test.

37. On 12 December, Mr Clare was evicted from his accommodation and the following day, a probation officer completed Mr Clare's recall to custody because he had been charged with a further offence of burglary and common assault.

38. On 16 December, Mr Clare was returned to Altcourse, after his warrant had been executed by the police, where Nurse A saw him for an initial health check. Mr Clare told her that he had last taken drugs two days earlier. He was referred to the SMS.

39. On 17 December, Mr Clare saw Mr A who gave him harm minimisation advice. Mr Clare confirmed that he was happy to engage with SMS services. Later that day, wing staff contacted healthcare staff to say that Mr Clare appeared under the influence.

40. On 19 December, Mr Clare was prescribed opiate substitution therapy. He saw a prison probation officer who emailed Ms A to confirm that a housing referral had been made to Cheshire East and Mr Clare's release date was 23 December. (Mr Clare's release date had been brought forward from 29 December because of the release arrangements in place during the Christmas and bank holiday period.) Later that day, an IOM case conference took place, where it was agreed that Mr Clare would again have red status on release.

41. On 21 December, Mr Clare was due to have a five-day SMS/clinical care review. However, this did not take place.

42. On 23 December, Nurse A saw Mr Clare before he was released from prison. She told the investigator that before they were released, all prisoners saw someone from the healthcare team who took a full set of clinical observations and gave them any prescribed medications they needed to take with them, in addition to naloxone for those with substance misuse issues. There is no record that Mr Clare was offered or given naloxone.

43. Shortly afterwards, Mr C, an SMS worker, gave Mr Clare an appointment letter for CGL which was scheduled for 3.00pm that day. Mr C told the investigator that prisoners who had received SMS support in prison received harm minimisation advice both verbally and in a document before they were released. He said that they would also encourage them to take naloxone.

44. At 3.00pm, Mr Clare met Ms A at the probation office. As he had arrived late, Ms A arranged for his appointment with CGL to be moved to the following day. She recorded that Mr Clare was homeless and was due to go to the council to request housing assistance after their appointment. A senior probation officer told the investigator that they did not explore a referral for CAS3 accommodation (short-term accommodation for prison leavers) as they knew he was considered a priority need and the local authority would therefore offer him accommodation. The local authority gave Mr Clare temporary YMCA accommodation in Runcorn.

Circumstances of Mr Clare's death

45. The police report noted that Mr Clare had returned to the YMCA intoxicated on 25 December and a support worker checked on him periodically throughout the night. At 7.15am on 26 December, the support worker found Mr Clare face down on his bed and tried to rouse him. When Mr Clare did not respond, the support worker called for an emergency ambulance. Paramedics attended and started cardiopulmonary resuscitation (CPR) but stopped when they identified signs of rigor mortis. They pronounced life extinct at 7.58am.

Post-mortem report

46. The post-mortem report concluded that Mr Clare had died from combined drug toxicity. The toxicology results indicated that Mr Clare had used cannabis, bromazolam (a psychoactive substance), cocaine and pregabalin before his death. Mr Clare also had left ventricular hypertrophy which did not cause but contributed to his death.

Inquest into Mr Clare's death

47. The inquest into Mr Clare's death was held on 3 July 2025 and a verdict of combined drug toxicity was recorded. The coroner concluded that Mr Clare's death was drug related.

Support for staff

48. Ms A confirmed that she was offered support following Mr Clare's death.

Findings

Substance misuse

49. Mr Clare had a history of substance misuse. As he had served a number of sentences at Altcourse, he was well known to Phoenix Futures. He was reviewed promptly after he was recalled and was placed on a methadone detoxification programme. Appointments were also made for him to receive treatment and support in the community before his release.

50. The investigator spoke to Mr D, the Head of Phoenix Futures, who said that he had worked with Mr Clare for over 10 years. He said that they had tried a number of substance misuse interventions with him, including one-to-one support, group therapy sessions and locating him in the substance recovery unit.

51. Mr D explained that when a prisoner with substance misuse issues arrived, they were initially located on a specific wing. During the first few days, the emphasis was on addressing any withdrawal issues (in line with clinical guidance) to stabilise them. He explained that individuals recalled to prison for 14 days only spent a few days in prison once they had been stabilised. This made it difficult to deliver meaningful psychosocial interventions.

52. Mr D said that he believed that Mr Clare's five-day review, which should have taken place on 21 December, did not happen because Mr Clare was due to be released two days later. We do not consider that this omission was significant in the circumstances as Mr Clare was frequently given harm minimisation advice and a nurse and an SMS worker saw him on the day of his release.

53. Mr Clare had been trained how to use naloxone during previous sentences and when he was released on 26 November, he was offered naloxone but refused. However, when he was released on 23 December, he was not offered naloxone. Nurse A told the investigator that it was standard practice for naloxone to be offered to those with a history of opiate misuse but she could recall why she did not do this for Mr Clare. Nurse A said that there was a reminder on the discharge template used when discharging a prisoner from healthcare but it was easy to miss.

54. Mr Clare had refused naloxone in the past but we cannot establish if he would have accepted it if it had been offered to him on 23 December. In addition, the post-mortem report does not specify whether Mr Clare had used an opiate before his death. We therefore do not make a recommendation.

Pre-release engagement and planning

55. Mr Clare was managed through the IOM system. This meant that a number of different agencies had comprehensive arrangements in place to support Mr Clare with his rehabilitation and to ensure his risks were appropriately managed. While Mr Clare left Altcourse on 23 December without accommodation in place, we

understand that this was because the COM knew that the local authority would provide accommodation (as they had a legal duty to do so as Mr Clare was considered a priority need) and an application could only be made on the day he became homeless.

Adrian Usher **October 2025**
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