Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Lonsdale, on 14 December 2024, following his release from HMP Lewes

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. 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.

3. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

4. Mr Robert Lonsdale died from heroin and n-desethyl etonitazene (a synthetic opioid) toxicity on 14 December 2024, following his release from HMP Lewes on 6 December 2024. He was 42 years old. We offer our condolences to those who knew him.

5. Mr Lonsdale had a history of substance misuse and had periods of abstinence. He engaged with the substance misuse team in prison and appeared focused on his recovery. He was provided with details of community substance misuse services in the event he wanted to self-refer on release.

6. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Lonsdale.

7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Lonsdale's death on 6 January 2025.

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

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

11. The Ombudsman's office contacted Mr Lonsdale's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Lonsdale's next of kin had no questions but asked for a copy of our report.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

13. Mr Lonsdale's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Lewes

14. HMP Lewes is a category B local prison which holds convicted and remand male prisoners. It is managed by HMPPS. Practice Plus Group provides healthcare services.

Probation Service

15. 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

16. On 4 October 2024, Mr Robert Lonsdale was remanded to HMP Lewes, charged with threatening with a bladed article.

17. A nurse completed Mr Lonsdale's initial health screen. Mr Lonsdale said that he had not used heroin, cocaine or drunk any alcohol for five months but he had relapsed two days prior to coming to prison, when he drank a lot of alcohol and used cocaine. He said he was then arrested while under the influence of alcohol and drugs.

18. Mr Lonsdale said he was prescribed mirtazapine (antidepressant) and olanzapine (antipsychotic) for depression and anxiety. The nurse re-prescribed these medications to Mr Lonsdale. Mr Lonsdale asked for support from the substance misuse team to address his drug and alcohol use. He engaged with the substance misuse team during his time at Lewes.

Pre-release planning

19. On 7 October, a member of the substance misuse team completed an assessment with Mr Lonsdale. Mr Londsdale said that he had previously attended a drug rehabilitation centre five times and had remained drug free several times before. He said he was not currently craving any drugs and was motivated to change. He declined the offer of a naloxone kit on release and was placed on the waiting list for SMART (self-management and recovery training). Mr Lonsdale did not attend any of the sessions prior to his release due to the long waiting list.

20. Mr Lonsdale declined a referral to CGL (Change, Grow, Live, the local drug and alcohol service in Brighton) therefore he was not offered an appointment on release. Mr Lonsdale declined the referral because he said that he had not relapsed with opiates and said that he was confident about remaining abstinent on his release. However, following the assessment, the member of the substance misuse team sent a continuation of care form to CGL and provided Mr Lonsdale with their contact details in the event he decided to self-refer on release.

21. Also on 7 October, a member of the mental health team completed an assessment. Mr Lonsdale said that he had previously been sectioned because he heard voices and had been diagnosed with drug induced psychosis. He said that his mental health was the best it had been, and he had managed it well in the community with medication and support. Mr Lonsdale said he would engage with psychology groups in prison if he was given a custodial sentence, however he was expecting to receive a suspended sentence and told her that he knew how to seek support from community mental health services if he needed to. Mr Lonsdale had no further contact with the mental health team at Lewes.

22. On 9 October, the member of the substance misuse team spoke to Mr Lonsdale's key worker at ONE CIC Housing, where Mr Lonsdale was living prior to prison. The key worker confirmed Mr Lonsdale's room was still available for him on release. The substance misuse worker relayed this information to Mr Lonsdale.

Post-release management

23. On 6 December, Mr Lonsdale was convicted of threatening with a bladed article and received a 24-month suspended sentence. He was released from court that day.

24. Mr Lonsdale attended his initial probation appointment with his Community Offender Manager (COM). Mr Lonsdale said that his main goal was to get support with his recovery and that he had already been in touch with his previous sponsor. She supported Mr Lonsdale in searching for upcoming alcoholics anonymous (AA) and narcotics anonymous (NA) support meetings and he bookmarked a few he planned to attend. She encouraged him to contact his sponsor for additional support. She noted that Mr Lonsdale appeared motivated to seek support for his drug and alcohol issues. Mr Lonsdale was given his next probation appointment for 18 December.

25. There is no evidence that Mr Lonsdale self-referred to the local drug and alcohol service, that he contacted his sponsor or attended any AA/NA meetings in the community.

Circumstances of Mr Lonsdale's death

26. At 5.56pm on 14 December, Mr Lonsdale's flatmates became concerned as they had not seen him since the previous day, when he was injecting heroin. His door was open and they noticed an unusual smell coming from his room. They entered his room and found him slumped on the floor. Mr Lonsdale was unresponsive, cold to touch and stiff. His friends called the emergency services.

27. At 6.03pm, the paramedics arrived and confirmed there were obvious signs of rigor mortis. At 6.06pm, the paramedics pronounced life extinct.

28. Large amounts of drug paraphernalia were found around Mr Lonsdale's room.

Post-mortem report

29. The post-mortem report concluded that Mr Lonsdale died from heroin and n-desethyl etonitazene toxicity (a synthetic opioid).

Findings

30. Mr Lonsdale had a history of substance misuse. While he was in prison, he engaged with the substance misuse team, appeared motivated to remain abstinent and was advised about the risks and dangers of taking drugs. He declined a supply of naloxone kits and did not take one on release. Mr Lonsdale did not want an appointment arranged with the local drug and alcohol service for him on release, however he was given their details if he wanted to self-refer and the substance misuse team at Lewes ensured the local drug and alcohol service were aware of him if he did decide to make contact.

31. Mr Lonsdale's COM supported him to look for local AA/NA meetings to ensure he received the additional support he needed for his drug and alcohol issues in the community. We are satisfied that both the prison and probation services did all they could to manage the risks associated with his substance misuse.

32. We make no recommendations.

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

At the inquest held on 13th August 2025 the coroner concluded Mr Londale's cause of death was drug related.

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