

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Louis Dalmasso, on 20 August 2023, following his release from HMP Bristol**

**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 Louis Dalmasso died of respiratory depression (slow breathing resulting in a build-up of carbon dioxide) caused by fentanyl toxicity (synthetic opioid poisoning) on 20 August 2023, following his release from HMP Bristol on 14 August. He was 39 years old. I offer my condolences to those who knew him.
5. Mr Dalmasso had regular meetings with probation services during which the use of cocaine and alcohol was discussed. In March 2023, his Community Offender Manager (COM) decided that she would refer him for substance misuse support. However a referral was never made.
6. On release from prison, Mr Dalmasso's COM cautioned him about his use of drugs and told him that he would be regularly tested.
7. We do not make any recommendations. However, we identified that the COMs involved in Mr Dalmasso's case were not offered support after they had been told that he had died.

## The Investigation Process

8. HMPPS notified us of Mr Dalmasso's death on 23 August 2023.
9. The PPO investigator obtained copies of relevant extracts from Mr Dalmasso's prison and probation records.
10. We informed HM Coroner for Somerset 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 Dalmasso's mother to explain the investigation and to ask if he she had any matters she wanted us to consider. She did not respond.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Bristol

13. HMP Bristol is a category B reception prison which holds up to 580 male prisoners who have either been convicted or are on remand. GP and mental health services are provided by Oxleas NHS Foundation Trust. Substance misuse services are provided by Change Grow Live.

### Probation Service

14. 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 supervise people throughout their licence period and post-sentence supervision.

## Key Events

15. On 11 May 2022, Mr Louis Dalmasso was convicted of criminal damage and he was given an eighteen-month suspended sentence. One of the terms of the suspended sentence order was for Mr Dalmasso to keep in regular contact with his supervising officer and attend all appointments.
16. In March 2023, Mr Dalmasso's COM completed an Offender Assessment System (OASys) risk and needs report for Mr Dalmasso. The report noted that Mr Dalmasso said that he used cocaine intermittently and did not have any concerns about doing so. She concluded that Mr Dalmasso did not understand that any level of drug use was problematic. She recorded that Mr Dalmasso should be referred to a substance misuse service (SMS) to support him to reduce his substance use. However, she did not refer him.
17. On 4 July, following an alleged breach of the suspended sentence order, Mr Dalmasso was sent to HMP Bristol. A nurse completed his initial health screen that day. Mr Dalmasso told her that he did not drink alcohol and had not previously taken drugs.
18. On 9 August, Mr Dalmasso was found guilty of breaching a restraining order. He was sentenced that day and his release date was calculated as 14 August 2023 (five days later).
19. In the afternoon of 14 August, Mr Dalmasso was released. Before leaving prison, Mr Dalmasso was given his prescribed medication and his license agreement. One of the conditions of his license was for him to report to Yeovil Probation Office at 1.00pm on 14 August. However, this appointment was changed to 15 August due to the delay in him leaving prison.
20. On 15 August, Mr Dalmasso reported to the Yeovil Probation Office, where he had a supervision meeting with a different COM. During their meeting, they discussed substance misuse, and she confirmed that Mr Dalmasso would be tested for drugs. She noted that she discussed steroid use with him (because he had a known history of steroid use) and warned him that a combination of steroids and his other medications could affect his heart. She said that Mr Dalmasso was confident that any drug tests would come back clean.

## Circumstances of Mr Dalmasso's death

21. On 20 August, the police informed HMPPS that Mr Dalmasso had been found dead at a private address. They suspected that he died of a drug overdose as there was drug paraphernalia in the room. Information provided to the police indicated that Mr Dalmasso had helped himself to another person's medication.

## Post-mortem report

22. The post-mortem report concluded that Mr Dalmasso died of respiratory depression (slow breathing which results in a build-up of carbon dioxide) caused by fentanyl (a synthetic opioid normally prescribed for pain relief) toxicity.

### **Inquest into Mr Dalmasso's death**

23. The inquest into Mr Dalmasso's death was held on 24 November 2025 and a verdict of drug related death was recorded. The coroner concluded that Mr Dalmasso's death was due to respiratory depressions caused by fentanyl toxicity.

### **Support for staff**

24. Both of the COMs involved with Mr Dalmasso's supervision told the investigator that they were not offered any support following the news of his death. They both said that they would have found support beneficial in the circumstances.

## Findings

25. Mr Dalmaso was known to use cocaine occasionally. However, he did not consider his drug use as problematic and was dismissive of needing any support.
26. When Mr Dalmaso arrived at HMP Bristol, he told staff that he had never used drugs. Therefore, the prison did not consider it necessary to refer him to substance misuse services.
27. Mr Dalmaso's COM told the investigator that she did not make a referral to community SMS in March 2023, as Mr Dalmaso was dismissive of needing support and because he entered custody a short while afterwards.

## Regional Probation Director to note

28. While it may not have made any difference given the circumstances of Mr Dalmaso's death, there were three months between the COM considering that Mr Dalmaso should be referred to community substance misuse services and his return to prison, which we consider was ample time for a referral to have been made.
29. Both COMs involved in Mr Dalmaso's case told the investigator that they would have benefitted from support after being told of his death but it was not offered.

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

**March 2024**



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