Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nicholas Lowe, on 16 October 2025, following his release from HMP Five Wells

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 Nicholas Lowe died from the toxic effects of synthetic cannabinoids on 16 October 2025, the day after his release from HMP Five Wells. He was 44 years old. We offer our condolences to those who knew him.

5. Mr Lowe had a history of drug use and was resident on the drug rehabilitation unit at Five Wells up to his release. We found that he received appropriate support.

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

7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Lowe's death on 12 December 2025.

9. The PPO investigator obtained copies of relevant extracts from Mr Lowe'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 Lowe's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He asked us to clarify why Mr Lowe was released from Five Wells, why he arrived late to his release address, and for more information on the circumstances of his death. We have addressed these issues in our report.

12. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

13. We sent a copy of our initial report to Mr Lowe's brother. He did not notify us of any factual inaccuracies.

Background Information

HMP Five Wells

14. HMP Five Wells is a category C male resettlement prison. It is managed by G4S. Practice Plus Group provides primary healthcare, mental health services, and substance misuse 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.

Deaths following release from prison

16. Between September 2021 and the end of April 2026, the PPO started investigations into approximately 300 deaths of people who died within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health and substance use issues and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from HMP Five Wells

17. Mr Lowe was the second man to die within 14 days of release from Five Wells since October 2022. The other death was due to natural causes. Up to the end of April 2026, there have been two further deaths, one from natural causes and one that is awaiting classification. We found that there were no issues with pre-release planning or post-sentence supervision in our investigation into the previous death.

Key Events

Background

18. On 17 July 2025, Mr Nicholas Lowe was arrested for breaching his community behaviour order and burglary of a shop. He was remanded in prison and taken to HMP Lewes.

19. On 15 August, Mr Lowe was sentenced to 14 months in prison for criminal damage. He returned to Lewes.

20. On 27 August, Mr Lowe was moved to HMP Five Wells. While being transferred in the escort van, he took psychoactive substances (PS, synthetic drugs designed to mimic illegal drugs). Staff called for an ambulance and Mr Lowe was taken to hospital. When discharged, he was returned to Five Wells.

21. On 2 September, Mr Lowe was moved to the drug rehabilitation unit (DRU) at Five Wells after staff found him under the influence of drugs on three consecutive days. While on the DRU, Mr Lowe attended weekly Alcoholics Anonymous and Narcotics Anonymous groups and remained in the DRU until his release.

22. On 4 September, Mr Lowe told a substance misuse service (SMS) worker that he wanted to restart quetiapine (an antipsychotic medication that helps mood stability) and diazepam (a benzodiazepine that helps with symptoms of anxiety) for his mental health and that he had an appointment booked with the mental health team to discuss.

Pre-release planning

23. On 30 September, Mr Lowe and his community offender manager (COM) had a telephone call with Change Grow Live, the community substance misuse provider. They discussed whether Mr Lowe would consider going to rehab on release. Mr Lowe said he was substance free and did not think he needed rehab. They agreed that the COM would instead arrange an assessment with Filey Care and Support, a supported living provider for adults with complex needs. During the call, Mr Lowe told the COM he had recently stopped taking his mental health medication, and the COM emailed healthcare staff to request an update.

24. On 13 October, Mr Lowe's prison offender manager (POM) and COM received confirmation that a room was available for Mr Lowe in supported accommodation. They agreed with the Offender Management Unit (OMU) that Mr Lowe would be released on 15 October, to allow time for them to complete the release checks. Mr Lowe was being released under Home Detention Curfew (HDC, allows prisoners assessed as low risk to finish part of their sentence at home, under strict rules and electronic monitoring).

25. Later that day, Mr Lowe saw a mental health nurse in the clinic. Mr Lowe said he was being released in two days' time and wanted to start antipsychotic medication again as he was struggling with hearing voices. The nurse did not see any signs of psychosis in Mr Lowe's presentation but agreed to restart him on quetiapine

(100mg daily) and issued a prescription for 28 days. They agreed for a review with his community GP in six weeks.

Release from HMP Five Wells

26. On 15 October, at around 6.13pm, Mr Lowe was released from Five Wells on HDC. The delay in his release was due to the prison awaiting confirmation from the police that no action would be taken in relation to an outstanding disciplinary charge. He saw a nurse in reception before he left and declined assistance with registering for a GP. He told the nurse that he was on medication but did not need it and he planned to throw it down the toilet.

27. Mr Lowe was released to St Martins Place, a Filey Care and Support accommodation that provides support to prison leavers with complex mental health and substance misuse needs.

28. Mr Lowe arrived at the accommodation at around 10.00pm. He told staff that he had arrived in Brighton earlier, at around 9.00pm, but had gone for a drink with a friend first. Staff showed him to his room, and he said he was very happy with the placement. Mr Lowe then told staff that he was going to sleep.

29. Mr Lowe was due to have an electronic curfew tag fitted. However, as he arrived at his accommodation later than expected, he missed the appointment. This was due to be rearranged.

Circumstances of Mr Lowe's death

30. On 16 October, at around 10.20am, a member of staff found Mr Lowe unresponsive in his room. He was sitting on the bed near the window, holding a lighter. The staff member phoned for an ambulance and started CPR.

31. An ambulance arrived at 10.26am. Paramedics observed signs of rigor mortis (stiffening of the body after death) and decided that CPR was not appropriate. They asked staff to stop CPR. At 10.29am, paramedics pronounced life extinct.

Post-mortem report

32. The post-mortem report concluded that Mr Lowe died from MDMB-4en-PINACA (synthetic cannabinoid) toxicity. Emphysema with bronchopneumonia (lung diseases) were listed as contributory factors.

Findings

Substance use

33. Mr Lowe was referred to the substance misuse service at Five Wells and agreed to engage with psychosocial support, in the form of group therapy sessions. He was also a resident on the drug rehabilitation unit (DRU). Mr Lowe declined a referral to the community SMS prior to his release. We consider that he received appropriate support with his substance use.

Housing

34. Mr Lowe's POM worked with him to apply for release under HDC. His COM made the appropriate housing referrals for him and secured a suitable placement, which was designed to support people with complex needs. We consider that Mr Lowe's placement for HDC was appropriate.

35. We make no recommendations.

Adrian Usher
Prisons and Probation Ombudsman **August 2026**

Inquest

36. At the inquest, held on 8 July 2026, the Coroner concluded that Mr Lowe's death was drug related.

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