Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Evans, a prisoner at HMP/YOI Lewes, on 28 June 2022

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

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Andrew Evans died from isotonitazene toxicity on 28 June 2022 at HMP Lewes. He was 34 years old. I offer my condolences to Mr Evans' family and friends.

Mr Evans was the second of two prisoners to die of isotonitazene (a synthetic opioid) toxicity on the same day and on the same wing at Lewes.

This was Mr Evans' first time in prison. He was identified as requiring drug detoxification when he arrived at prison custody and completed this and engaged positively with the substance misuse service. There were no changes in his behaviour or attitude in the days leading to his death that suggested he was using drugs. I am concerned, however, that when Mr Evans' mail was intercepted for routine testing, it was positive for cocaine. Prison staff did not inform the substance misuse service so there was no process in place to offer him support and assess his risks or any potential consequences he might face. I am also concerned that prison staff failed to complete two roll checks on 27 June as they should have done.

I recognise that HMP Lewes has in place robust measures to try and reduce the number of illicit items finding their way into the prison, and these measures are being deployed consistently. However, the Governor should continue to identify and address weaknesses in measures to prevent supply of drugs into Lewes and revise the substance misuse strategy in light of the findings.

The clinical reviewer concluded that the healthcare and substance misuse care Mr Evans received at Lewes was equivalent to that which he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

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Summary

Events

1. On 7 August 2020, Mr Andrew Evans was remanded to HMP Elmley. It was his first time in prison. Mr Evans told staff that he had taken illicit drugs in the community and as a result they placed him on a detoxification programme.

2. On 6 November, Mr Evans received some external mail. Prison staff conducted a routine test, and his letter was positive for 'Spice', a psychoactive substance (PS). Prison staff told Mr Evans that his mail had been seized, but they did not take any further action.

3. On 25 February 2021, Mr Evans appeared in court via video link. He was sentenced to four years in prison for conspiracy to supply class A drugs. Following his video link appearance, nursing staff saw him in the reception area to check on his well-being. Mr Evans said that he had no thoughts of suicide or self-harm.

4. On 19 March, Mr Evans was transferred to HMP Lewes. He was located on L wing. He settled in well and engaged with his key worker sessions and the prison's Substance Misuse Services (SMS) team.

5. In November, prison staff intercepted a letter addressed to Mr Evans. The letter tested positive for cocaine. Prison staff did not take any further action. No further intelligence or security issues were raised about Mr Evans after this date.

6. At 5.30pm on 27 June, Mr Evans was locked in his cell for the night. This was the last time he was seen alive.

7. At 7.40pm, an Operational Support Grade (OSG) began his shift. He was required to complete a full roll check, but he did not do so. A roll check is primarily a security check to count each prisoner to ensure that they are present in their cells. The OSG was required to complete another roll check at 8.45pm, but he failed to do so.

8. At approximately 5.06am on 28 June, the OSG started the morning roll check on L wing. When he checked on Mr Evans, he saw him sitting 'slumped' on his bed. He was satisfied that he saw Mr Evans move and that he was breathing.

9. During the roll check, the OSG found that another prisoner had covered the observation panel of his cell door. The OSG told a Custodial Manager (CM) and asked her to attend L wing to check on the prisoner. When they checked on him, it was clear that he was dead. At 5.49am, paramedics arrived and confirmed that the prisoner had died. While in the cell, staff found drug paraphernalia (burnt rolled up tin foil) and considered that the prisoner's death might have been drug related.

10. In light of this incident, the OSG asked the CM to check on Mr Evans because he wanted to be sure that he was alive and well. The CM checked on Mr Evans. She thought she saw Mr Evans breathing and moving but was unable to get a response from him. As a precaution, the CM asked nursing staff to come to the cell, along with the paramedics who were still in the prison.

11. When the staff entered the cell, Mr Evans was unresponsive and cold, and it was clear he was dead. They found drug paraphernalia beside his bed. The paramedics confirmed that Mr Evans had died.

Findings

12. Mr Evans was able to source and use illicit drugs, which caused his death.

13. We are concerned that when prison staff intercepted a letter addressed to Mr Evans in November 2021, it contained traces of cocaine. There is no evidence that staff took any further action or informed the SMS team. As a result, there was no process in place to offer Mr Evans support and assess his risks or any potential consequences he might face.

14. We are concerned that prison staff failed to complete two roll checks at 7.30pm and 8.45pm on 27 June as they should have done.

15. The clinical reviewer concluded that the healthcare and substance misuse care Mr Evans received at Lewes was equivalent to that which he could have expected to receive in the community.

Recommendations

The Governor should review the local drug strategy and ensure that where mail is intercepted and is positive for illicit substances, the intended recipient is referred to the prison's Substance Misuse Services Team and record that the referral has been made.

The Governor should continue to identify and address weaknesses in measures to prevent supply of drugs into Lewes and revise the substance misuse strategy in light of the findings.

The Governor should ensure that staff completing roll checks satisfy themselves that prisoners are alive and well.

The Governor should ensure that all staff understand of the importance of conducting roll checks at the prescribed times and record the time the roll check is completed in the daily diary, in line with the Local Security Strategy.

The Governor should inform the PPO of the outcome of the disciplinary investigation into the actions of the OSG on 27 June 2022.

16. HMP Lewes accepted all the recommendations made.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP/YOI Lewes informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

18. The investigator obtained copies of relevant extracts from Mr Evans' prison and medical records.

19. The investigator interviewed seven members of staff at Lewes on 24 August and 27 September.

20. NHS England commissioned a clinical reviewer to review Mr Evans clinical care at the prison. The investigator and clinical reviewer jointly interviewed three healthcare staff.

21. We informed HM Coroner for East Sussex of the investigation, who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

22. An inquest was concluded on 26 February 2024 and concluded that Mr Evans died as a result of misadventure by drug related overdose. This was caused by a synthetic opioid namely isotonitazene. Due to the potency of the drug, 500 times more powerful than Morphine, it is likely they became unconscious very quickly and died.

23. The Ombudsman's family liaison officer contacted Mr Evans' mother to explain the investigation and to ask if she had any matters, she wanted us to consider. Mr Evans' mother said that her son had written in his diary that he had been to the gym and the activities he did there, so she did not think that he was feeling down. Mr Evans' mother asked how drugs were available in the prison. We have addressed this question in the report.

24. Mr Evans' family received a copy of the initial report and highlighted no factual inaccuracies and did not comment on the findings. An extension was granted to the family legal representatives for responding to the initial report. No response has been received.

Background Information

HMP Lewes

25. HMP Lewes is a local prison serving the courts of East and West Sussex, holding up to 624 men.

HM Inspectorate of Prisons

26. The most recent unannounced full inspection of HMP Lewes was in May 2022. Inspectors found that the prison had identified and was responding to the key threats that it faced, most notably the use of drugs and alcohol. A body scanner used on all arriving prisoners had identified 96 illicit items in the previous 12 months. An 'itemiser' (a machine used to detect drugs in or on items such as paper) was used on all incoming post.

27. Inspectors also noted that in the previous six months, staff had submitted 3,278 intelligence reports, which was similar to the number at the time of the last inspection. The prison had identified that reports were not coming from across the prison, including areas where there were known to be issues, and were taking steps to raise awareness of the reporting process.

28. In a survey carried out by the inspection team, 37% of respondents said that it was easy to get drugs in the prison, which was similar to the proportion at the time of the last inspection. Mandatory drug testing had been suspended at the beginning of the pandemic, only consistently resuming in March 2022. Results suggested lower rates of drug use than at the time of the previous inspection.

29. However, in February 2023, HM Inspectorate carried out a review of the progress being made at HMP Lewes. In their report they said that eight months on from the full inspection, their latest visit found a worrying lack of overall progress at Lewes. Time out of cell was among the worst they had seen outside pandemic restrictions, and they were left concerned for prisoners' well-being. The report said that it was notable that the number of calls to the Samaritans was escalating. The report concluded that without significant further action to stabilise officer numbers, the situation at Lewes was unlikely to improve.

Independent Monitoring Board

30. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to January 2022, the IMB reported that all prisoners should be safer now that everyone entering the prison was searched. They thought this would reduce the number of illicit substances entering the prison, which were often linked to cases of bullying and violence.

Previous deaths at HMP Lewes

31. Mr Evans was the fifteenth prisoner to die at Lewes since March 2020. Of the previous deaths three were self-inflicted. On the day of Mr Evans' death, another

prisoner was found dead on L wing and in similar circumstances to that of Mr Evans. Mr Evans was one of two prisoners that died on the same day from using the same drug.

Psychoactive Substances (PS)

32. PS (formerly known as 'legal highs') continue to be a serious problem across the prison estate. They can be difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

33. Synthetic opioids such as isotonitazene are considered to be one of the fastest growing groups of psychoactive substances. Isotanitazine has no accepted medical use and is thought to be up to one thousand times more potent than morphine. Due to this, even handling the substance is considered to be high risk. While isotonitazene is fairly new to the illicit drug scene in the UK, in 2021 there were 24 deaths attributed to its use.

Key Events

34. On 7 August 2020, Mr Evans was remanded to HMP Elmley charged with conspiracy to supply class A drugs. This was his first time in prison.

35. When Mr Evans arrived at reception at Elmley, healthcare staff completed an initial health screen. They recorded that he was a drug user and urine sample test results were positive for opiates and cocaine. Mr Evans told staff that he had last used heroin the previous day. Mr Evans also said that he had been on a methadone programme in the community until March 2020. Healthcare staff placed him on a methadone detoxification programme, under the care of the prison's Substance Misuse Service (SMS). Mr Evans did not report any physical or mental health issues. He said that he had no thoughts or intentions of suicide or self-harm.

36. On 8 August, healthcare staff completed a secondary health screen. Mr Evans raised no issues or concerns. During his time at Elmley, Mr Evans continued to engage with the SMS, and he was engaged with the methadone detoxification programme.

37. On 6 November, the prison intercepted a letter addressed to Mr Evans for routine testing. The letter tested positive for 'Spice,' (PS). Prison staff told Mr Evans that they had seized the item. There is no recorded evidence to indicate that staff took any further action.

38. On 25 February 2021, Mr Evans appeared in court via video link and was sentenced to four years in prison. Following his court appearance, nursing staff saw him in the reception area to check on his well-being. The nurse recorded that he was calm and relaxed. He expressed no agitation, denied being depressed and said that he had no thoughts of suicide or self-harm.

39. On 19 March 2021, Mr Evans was transferred to HMP Lewes.

40. Prison staff carried out a first night interview with Mr Evans. He said that he had no history of self-harm and had no current thoughts of suicide. He said that he had issues with drugs and was currently on methadone.

41. Prison staff recorded in his prison record that Mr Evans had settled in well at the prison. He had positively engaged with his key worker sessions and the SMS. As a result of his positive behaviour, Mr Evans was placed on the enhanced regime under the Incentives and Earned Privileges (IEP) scheme and began working in the wing servery.

42. On 11 October 2021, a member of staff submitted a security intelligence report (IR) which indicated that a number of prisoners, including Mr Evans, had received money from the same source. Staff monitor monies sent to prisoners because this can sometimes be an indicator of bullying and/or drug use, as well as other issues that could affect the security of the prison. This information was added to Mr Evans' security file in order to build a picture of possible negative behaviours. There was no other information to substantiate that the money was being sent in due to bullying or drugs, therefore staff took no further action.

43. On 25 October, staff submitted another IR on A wing noting the contents of a letter which had been written by an anonymous prisoner. The letter alleged that cleaners on A wing were trying to encourage other prisoners to use crack cocaine and heroin. Although no prisoners were named, the officer who submitted the IR said that they had checked the spending accounts of those employed on the wing, which indicated that there were several prisoners that had received monies from the same source. One of those prisoners was Mr Evans. Prison staff used this information to build a bigger picture of the situation, but there was nothing to directly link the monies with criminal activity and so they did not take any further action or discuss it directly with Mr Evans.

44. On 9 November, a further IR was submitted which indicted that a letter addressed to Mr Evans had tested positive for cocaine. The investigator was told that it was not routine for a prisoner to be informed that items addressed to them had been seized in such circumstances. However, there is no evidence that prison staff informed the SMS, even though Mr Evans was fully engaged with them at that time and still on a methadone detoxification programme. There were no further IRs submitted about Mr Evans after this date.

45. On 8 January 2022, a practitioner from the SMS team saw Mr Evans. Mr Evans said that he felt stable on his current dose of 5mgs of methadone and wanted to reduce this to 4mgs. She sent a task to the substance misuse doctor to amend the dose. SMS staff continued to see Mr Evans and reduce his methadone dose. On 30 January, Mr Evans completed his methadone treatment programme. He continued to see a SMS practitioner. She told us that she provided Mr Evans with Guided Self-Help materials and spoke to him about remaining abstinent from illicit substances.

46. On 4 February, Mr Evans moved to L wing, which is primarily for prisoners on an enhanced regime and who work across the prison in trusted positions. Mr Evans was employed in the staff restaurant. Staff continued to make positive entries in Mr Evans' prison record about his behaviour both on the wing and while at work and about his positive attitude toward staff and other prisoners. The SMS practitioner noted that Mr Evans was open to talking about his previous life experiences and said that he was focused on doing everything he could to address his drug addiction and to prevent relapsing into drug misuse.

47. On Saturday 25 June, an officer recorded that she had spoken to Mr Evans as part of a routine welfare check. Mr Evans was unhappy that prisoners on L wing would not have as much time out of their cells that weekend due to reduced staffing levels, but he understood the reasons for this. He raised no other issues.

Events of 27 and 28 June

48. At around 5.30pm on 27 June, prison staff locked Mr Evans in his cell after collecting his evening meal. As there was no evening association that day, this was the last time he was seen alive.

49. At approximately 7.40pm, an Operational Support Grade (OSG) attended L wing to start the night shift. He said that when he arrived on the wing, two members of staff that had been on day shift provided a brief handover and indicated that there were

no issues. He said that he answered a number of cell bells and then checked prisoners subject to suicide and self-harm monitoring.

50. The OSG said that as he went around the wing, he checked to ensure all the cell doors were locked but he did not look into each cell as he did so. He told the investigator that he knew that he should have completed a roll check, which involves visually checking each prisoner, when he started his shift at 7.30pm and again at 8.45pm, but that he had failed to do so. The roll reported/recorded by him was therefore done without any check taking place.

51. Mr Evans did not ring his cell bell during the night.

52. At 5.06am on 28 June, the OSG began completing a morning roll check on L wing. When he arrived at Mr Evans' cell, he saw Mr Evans sitting slumped on his bed. He stayed at the door to observe Mr Evans, and was satisfied that he saw Mr Evans move, which suggested to him that Mr Evans was breathing. He continued to conduct the roll check on the wing.

53. During the roll check, the OSG discovered that another prisoner on the opposite side of the landing had covered the observation panel of his cell door and was not responding. After completing his roll check, he raised this as a concern with a Custodial Manager (CM), who was the most senior officer in charge at that time. The CM told the OSG that she would attend with other staff and that they would open the cell to check the prisoner's well-being.

54. CCTV shows staff arriving on the landing and entering the prisoner's cell. When the staff checked him, it was obvious that he was dead. Nursing staff attended and at 5.29am, control room staff called an ambulance. While staff were standing outside the deceased prisoner's cell, CCTV footage shows the OSG going across to Mr Evans' cell again and looking in through the observation panel.

55. At approximately 5.49am, paramedics arrived and confirmed the other prisoner had died. Staff found drug paraphernalia in his cell suggesting that his death could have been drug related.

56. CCTV footage shows all staff leaving the landing after the prisoner's cell was closed. The CM and OSG stayed behind. The OSG went back to Mr Evans' cell and called the CM across. CCTV shows them looking into the cell via the observation panel before leaving the landing. The CM told investigator that she recalled the OSG asking her to look in on Mr Evans as he had checked him earlier, and although he had been sure he had noted breathing, in light of the incident that had just occurred, he wanted to check. The CM said that when she looked in on Mr Evans, she thought she noted breathing and movement, but she was unable to get any response from him. As a precaution, she asked the nursing staff to come back up to Mr Evans' cell.

57. CCTV footage shows the CM and OSG briefly leaving the landing. Nursing staff returned to the landing followed by the CM, the OSG, an officer, and the paramedics. The CM said that when she entered the cell, she walked over to Mr Evans and reached out and touched him. She said that he was cold and unresponsive, and it was clear to her that he was dead. She also noted that there was drug paraphernalia (burnt rolled up tin foil) beside Mr Evans suggesting that his

death was also likely to be drug related. The paramedics confirmed that he had died.

Contact with Mr Evans family

58. Following Mr Evans' death HMP Lewes asked HMP Woodhill to appoint a family liaison officer (FLO) due to the distance to the family home from Lewes. HMP Woodhill appointed two FLOs. They visited the home address of Mr Evans' mother at 3.30pm on 28 June to inform her of her son's death. At his request, one FLO remained in contact with the family and updated staff at Lewes regularly.

59. The prison contributed to funeral expenses in line with national guidance.

Support for prisoners and staff

60. After Mr Evans' death, a prison governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

61. The prison posted notices informing other prisoners of Mr Evans' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the death.

62. In addition, the prison acted on intelligence and carried out searches to identify further illicit items. The prison also liaised with local police and Public Health England and provided advice to prisoners on the dangers of using synthetic opioids.

Post-mortem report

63. The post-mortem report gave Mr Evans' cause of death as Isotanitazine toxicity.

Findings

Assessment of Mr Evans' risk and substance misuse

64. When Mr Evans arrived in prison, he told staff that he had used cocaine and heroin in the community. He began working with the prison's substance misuse service and started a methadone detoxification programme, which he completed in January 2022. Staff raised no concerns about Mr Evans being under the influence of illicit substances during his time at Lewes.

65. In October and November 2021, there was suspicion that Mr Evans might be involved in illicit activity because he was among a small number of prisoners on A wing receiving payment from the same person. There were no further reports of suspicious activity involving Mr Evans after November and none of the information suggested Mr Evans was using drugs at Lewes.

66. HM Prison and Probation Service (HMPPS) has identified that using mail to bring drugs into prisons may be perceived as low risk and high reward, with perpetrators (both in and out of prison) unlikely to be caught or held accountable for attempting to bring illicit substances into prison.

67. HMPPS guidance 'Drugs in Prison – Supporting Operational Delivery', sets out the steps that prisons can take when they identify that mail is being used to bring illicit substances into prison. This includes gathering sufficient evidence or intelligence to assess the level of risk to the prison or intercepting and photocopying incoming prisoner social mail. The guidance does not instruct staff on other actions to take, such as referring the intended recipients to the prison's SMS.

68. In November 2021, staff at Lewes intercepted a letter addressed to Mr Evans as part of routine checks which tested positive for cocaine (this also happened at Elmley in November 2020). While there is evidence that security staff took action in line with the guidance, we consider that prison staff should have informed the SMS about the incident or made a referral on Mr Evans' behalf. Mr Evans was engaged with the SMS at that time and, had they been informed, they could have provided additional support and might have been able to provide further intelligence about the availability of illicit drugs at Lewes. We make the following recommendation:

    The Governor should review the local drug strategy and ensure that where mail is intercepted and is positive for illicit substances, the intended recipient is referred to the prison's Substance Misuse Service

Drug strategy at HMP Lewes

69. It is troubling that Mr Evans was the second of two prisoners to die on the same day from using the same rare synthetic opioid at Lewes. The use of synthetic substances is a concern across the prison estate and has a profoundly negative impact on the physical and mental health of prisoners, as well as being associated with debt and bullying. Mr Evans' death is an example of the dangers of illicit drugs and illustrates why prisons must do all they can to eradicate its use.

70. In April 2019, HMPPS issued a national instruction that all prisons should review their drug strategies. Lewes' Head of Security and Intelligence spoke to us about the steps Lewes was taking to reduce the supply of illicit substances. She told us that most of the local intelligence received about drugs had been around cannabis, fermenting liquid, and known types of PS, namely 'Spice' – a synthetic cannabinoid. She said that intelligence information was reviewed regularly at a tactical meeting held between herself and the Governor and was shared more widely at security committee meetings.

71. The Head of Security and Intelligence also said that there were a number of initiatives to try and reduce the supply of illicit items into the prison, including enhanced gate security, which is aimed at targeting those (including staff and visitors) trying to bring illicit items into the prison. All post was searched, including with drug dogs. She also authorised intelligence led monitoring if information was obtained from phone calls or through mobile phone detection. She explained that mobile phone detection could be linked with conveyance of items or payment, so regular monitoring of bank accounts was completed to ensure that there was nothing suspicious that could be linked to the illicit drug economy.

72. In addition, the security department at Lewes carries out regular security briefings on residential wings. They also monitor the visits lists to monitor those prisoners who are subject to intelligence information and provide a briefing for staff prior to visits. The Head of Security and Intelligence said that over weekends, security staff brief other officers on monitoring cameras and those prisoners requiring closer monitoring due to their possible involvement in the illicit economy. Staff were also able to utilise closed visits as a deterrent, mandatory drug testing, intelligence reports, and searching of communal areas with search dogs. Referrals to SMS and the Safer Custody Team were also widely used to tackle the availability of drugs and the illicit economy. She said that there was no intelligence linked to the synthetic opioid that Mr Evans took prior to his death.

73. The illicit economy is an ongoing issue facing the prison service and impacts on the safety and well-being of all those that live and work in prisons. While there are measures that can be taken to reduce the supply of illicit substances into secure settings, we are realistic that those intent on supplying this will continue to find ways of doing so. Despite the proactive steps being taken by Lewes, it is clear that Mr Evans and the other prisoner were able to obtain a synthetic opioid and died as a result. We make the following recommendation:

    The Governor should continue to identify and address weaknesses in measures to prevent supply of drugs into Lewes and revise the substance misuse strategy in light of the findings.

74. Following his death, the prison worked closely with local police in conjunction with Public Health England and their area safety team to ensure that information about the dangers of this particular drug was made available at the earliest opportunity to other prisoners and staff. Staff also acted on intelligence that was submitted on those prisoners who were thought to have been involved in its supply. Although staff carried out a number of searches, they did not find anything of concern and there was no further intelligence about the source of the drug.

75. We are satisfied that following Mr Evans' death the prison took immediate action, in partnership with local police and Public Health England, to identify the substance and communicate the potential seriousness of its effects to the wider prison community and provide advice to prisoners and staff.

Roll Checks

76. Roll checks are primarily a visual security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoners' safety to be identified and managed. HMPPS' National Security Framework expects welfare checks to take place at roll checks including that staff are able to see the prisoner's face and that they are alive and well.

77. The Local Security Strategy (LSS) at Lewes, which became effective from April 2022, sets out when prison staff should complete roll checks. It directs that roll checks should take place at various times including 5.30pm, 7.30pm and 8.45pm.

78. On 27 June, prisoners on L wing were locked in their cells at 5.30pm. It appears that this was the last roll check to be completed that day. The investigator found no evidence that prison staff completed roll checks at 7.30pm or 8.45pm, as they should have done. The OSG told the investigator that when he arrived for his duty, there were a number of cell bells to respond to. He was also aware that there were at least two prisoners who required additional welfare checks. He said that because he was immediately busy with these tasks, it was not until the following morning, 28 June, that he realised that he had not completed the two evening roll checks as he should have done. However, he would have had to sign for the roll at the start of his shift to indicate that it was correct.

79. Because the OSG did not complete two roll checks, it would appear that Mr Evans was last seen alive at 5.30pm. We do not know whether the OSG conducting the two evening roll checks would have made any difference to the outcome for Mr Evans, but roll checks are important for both prisoner safety and security.

80. The Governor told us that he is conducting an internal disciplinary investigation into the OSG's actions on the evening of 27 and 28 June.

81. We make the following recommendations:

The Governor should ensure that all staff understand of the importance of conducting roll checks at the prescribed times and record the time the roll check is completed in the daily diary, in line with the Local Security Strategy.

The Governor should inform the PPO of the outcome of the disciplinary investigation into the actions of the OSG on 27 June 2022.

Clinical and substance misuse care

82. The clinical reviewer concluded that the health and substance misuse care Mr Evans received at Lewes was equivalent to that which he could have expected to receive in the community. She made one recommendation about the substance

misuse services' record keeping, which we do not repeat in this report but which the Head of Healthcare will need to address.

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