

**Prisons &
Probation**

Ombudsman
Independent Investigations

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

A report by the Prisons and Probation Ombudsman

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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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 Tabone died of isotonitazene toxicity on 28 June at HMP Lewes. He was 58 years old. I offer my condolences to Mr Tabone's family and friends.

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

Mr Tabone had a history of using illicit substances in prison and his death appears to have been an accidental result of using drugs. When he arrived at Lewes, he was identified as needing a drug detoxification programme. However, he declined any engagement with the prison's substance misuse service. Prison staff did not find Mr Tabone under the influence of drugs during his time at Lewes and there were no changes in his behaviour or attitude in the days prior to his death that would have suggested he was using drugs.

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

My investigation also identified a continued culture at Lewes of prisoners covering their cell observations panels at night, with little evidence of proactive action taken to address the issue. Not only have I repeated my recommendations about this issue in this report, but I have also sought the Governor's reassurance that the advice promised to staff following an earlier PPO recommendation has been issued.

I am also concerned that a member of staff failed to complete two required checks on 27 June.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

October 2023

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Summary

Events

1. On 21 October 2021, Mr Giuseppe Tabone was remanded to HMP/YOI Lewes charged with conspiracy to supply Class A drugs. On 17 February 2022, he was sentenced to five years imprisonment. Mr Tabone had been in prison before and was known to staff at Lewes.
2. Mr Tabone was a known drug user and used illicit drugs in the community. On his arrival at Lewes, healthcare staff prescribed medication to alleviate his withdrawal symptoms and as a routine precaution, they observed him during the night between 21 – 25 October. Mr Tabone declined support from the prison's Substance Misuse Service (SMS).
3. Prison staff completed regular welfare checks on Mr Tabone and they did not raise any concerns about him. Mr Tabone moved from A wing to L wing, primarily for prisoners on an enhanced regime and who work across the prison in trusted positions. He initially worked in the prison kitchen and later as an orderly in the Care and Separation Unit (CSU).
4. On 27 June, Mr Tabone attended work in the CSU as usual. He returned to L wing at around 6.00pm. At 7.00pm, Mr Tabone was locked in his cell for the night. This appears to be the last time he was seen alive.
5. At 7.40pm, an Operational Support Grade (OSG) began his shift. He was required to complete a routine roll check of each prisoner on the wing at the start of his shift and again at 8.45pm, but he did not do so.
6. At approximately 5.06am on 28 June, the OSG started the morning roll check on L wing. When he arrived at Mr Tabone's cell, he saw that Mr Tabone had blocked the observation panel on his cell door. The OSG raised his concern with a Custodial Manager (CM). When they went into his cell, it was clear to them that he had been dead for some time. While in the cell, staff found drug paraphernalia, which suggested that his death was drug related.
7. A post-mortem examination concluded that Mr Tabone had died from isotonitazene (a synthetic opioid) toxicity.

Findings

8. Mr Tabone was able to source and use illicit drugs while at Lewes, which caused his death.
9. We are concerned that an OSG failed to complete two roll checks at 7.40pm and 8.45pm on 27 June as he should have done.
10. Mr Tabone had blocked the observation panel of his cell door. The blockage, and lack of clear local policy to deal with such incidents, contributed to a delay of ten minutes before Mr Tabone's cell was unlocked and he was found dead. We are also concerned that at the time of Mr Tabone's death, Lewes still had not issued a local

policy advising staff what to do in the event they find a cell observation panel blocked in accordance with national policy.

11. Although Lewes has taken steps to address its drug supply issues, Mr Tabone's death is a reminder that more needs to be done to reduce the availability of drugs. Mr Tabone was the first of two prisoners to die on the same day having used the same illicit drug. The availability of illicit substances remains a problem across the whole prison estate and should remain a priority for Lewes.
12. The clinical reviewer concluded that the healthcare and substance misuse care Mr Tabone received at Lewes was not equivalent to that which he could have expected to receive in the community. She was concerned about the lack of follow up substance misuse and mental health care Mr Tabone received.

Recommendations

- 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 all staff understand the importance of conducting roll checks and welfare checks at the prescribed times and record the time the roll check was 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.
- The Governor should ensure that:
 - prisoners who block their observation panels are challenged, blockages are removed, and frequent offenders receive appropriate disciplinary action or support;
 - staff are aware of national guidance and understand their responsibilities when they find a cell observation panel obscured;
 - they confirm with PPO that that a Safety Newsletter/handbook has been issued and the date this was completed.
- The Head of Healthcare and the Head of the Substance Misuse Service should ensure that healthcare staff:
 - complete follow up COWS assessments and appointments for prisoners who have previously displayed substance misuse withdrawal symptoms, to ensure continuity of care; and
 - record documentation relating to clinical rationale in the prisoners' medical records.

The Investigation Process

13. 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.
14. The investigator obtained copies of relevant extracts from Mr Tabone's prison and medical records.
15. The investigator interviewed seven members of staff at Lewes on 24 August and 27 September.
16. NHS England commissioned a clinical reviewer to review Mr Tabone's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three healthcare staff.
17. 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.
18. An inquest was concluded on 26 February 2024 and concluded that Mr Tabone 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.
19. The Ombudsman's family liaison officer contacted Mr Tabone's son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Tabone's son asked the following questions:
 - How were illicit drugs able to get into the prison?
 - What is HMP/YOI Lewes doing to prevent the supply of illicit drugs?

We have addressed these questions in this report.

20. Mr Tabone's family received a copy of our initial report but have not responded to our findings or highlighted any factual inaccuracies.

Background Information

HMP/YOI Lewes

21. HMP Lewes is a local prison serving the courts of East and West Sussex, holding up to 624 men. Practice Plus Group (PPG) provides primary care services and healthcare staff are on duty 24-hours a day.

HM Inspectorate of Prisons

22. The most recent unannounced 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.
23. 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.
24. 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. 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.
25. However, HM Inspectorate carried out a review of the progress being made at HMP Lewes in February 2023. 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

26. 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 amount of illicit substances entering the prison, which were often linked to cases of bullying and violence.

Previous deaths at HMP Lewes

27. Mr Tabone was the fourteenth prisoner to die at Lewes since March 2020. Of the previous deaths, three were self-inflicted. Mr Tabone was one of two prisoners that died on the same day from using the same drug.
28. In a previous investigation into the death of a prisoner at Lewes in May 2021, we recommended that prisoners who blocked their observation panels were challenged, blockages were removed, frequent offenders received appropriate disciplinary action or support, and that staff were made aware of the national guidance and understood their responsibilities when they found a cell observation panel obscured. The prison accepted our recommendations and provided us with an action plan which said that in February 2022, a Notice to Staff (NTS) was issued. However, during the course of this investigation, the prison told us that the NTS was not published because it was decided that something more robust was needed. At the time of Mr Tabone's death in June 2022, Lewes still had no local policy in place advising staff what to do in the event they found an observation panel obscured. It is concerning that we are raising the same issue again and repeating those recommendations in this report.

Psychoactive Substances (PS)

29. 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.
30. Synthetic opioids such as isotonitazene are considered to be one of the fastest growing groups of psychoactive substances. Isotonitazene 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

31. On 21 October 2021, Mr Giuseppe Tabone was remanded to HMP/YOI Lewes charged with conspiracy to supply Class A drugs. Mr Tabone had been in prison before and was known to staff at Lewes.
32. Mr Tabone had a history of illicit drug use since he was 17 years old. He took a range of illicit substances, including ketamine and crack cocaine. Mr Tabone told prison and probation staff that he had sold drugs to fund his illicit drug use and to pay his bills. In a probation self-assessment questionnaire, he said that taking drugs, being bored, being lonely, doing things on the spur of the moment, and feeling depressed and stressed were problems for him.
33. When he arrived at Lewes, prison staff conducted his first night interview. They noted that he was withdrawing from drugs and that he was keen to see a nurse and get his diabetic medication. Mr Tabone said that he had no history of self-harm or attempted suicide and denied any current thoughts or intent to self-harm.
34. Later that evening, a nurse completed his initial health screen. Mr Tabone told the nurse that he had been using crack cocaine and heroin and that he had depression and diabetes. The nurse referred him to the primary Intensive Home Based Treatment (IHBT) Service, part of the prison's Mental Health Service.
35. A substance misuse nurse completed Mr Tabone's drug screening. She recorded that Mr Tabone had been remanded to prison and was due to appear in court the following month for sentencing. Mr Tabone told her that he had been smoking around £20 - £40 worth of heroin per day, and while in police custody he had been prescribed withdrawal medication. She recorded that there were no obvious signs of withdrawal at that time, but urine sample results were positive for cocaine and opiates. She prescribed Mr Tabone symptomatic withdrawal medication.
36. On 22 October, a nurse from SMS completed an assessment with Mr Tabone, using a Clinical Opiate Withdrawal Scale (COWS) score (used by registered practitioners to measure the severity of a patient's opioid withdrawal symptoms). The result indicated that Mr Tabone was experiencing mild withdrawal symptoms. She offered him methadone to help reduce his withdrawal symptoms but recorded that Mr Tabone had said that he did not want to be prescribed methadone. She reassured him that he would continue to receive symptomatic relief until his withdrawal symptoms had subsided. He was also observed during the night between 21-25 October as part of the routine withdrawal observations, and staff did not raise any concerns during this time. Mr Tabone declined any further help from SMS, he said that he intended to remain drug free while in prison, and so he was not added to their caseload.
37. On 28 October, Mr Tabone attended a mental health triage appointment with a nurse. Mr Tabone said that he was struggling with low mood and suicidal thoughts but had no current thoughts of harming himself. He said that he was frustrated because he had not received his medication for his depression and to help with his sleeping, and that he had been prescribed mirtazapine in the community. She prescribed him an alternative medication.

38. Prison staff completed regular welfare checks on Mr Tabone. They recorded that he displayed a positive attitude and behaviour, they had no concerns about him and that he did not raise any concerns with staff. He moved from A wing to L wing and got a job in the prison kitchen.
39. On 6 December, a nurse completed a mental health review and welfare check with Mr Tabone. Mr Tabone said that he was unhappy with his current medication, and that since being on different medication his sleep was poor. Mr Tabone told her that he was due to appear in court on 23 December, and that he no thoughts of suicide or self-harm.
40. Prison staff continued to record positive entries about Mr Tabone's behaviour. They did not raise any concerns about him. Mr Tabone also worked as the orderly in the Care and Separation Unit (CSU), which was considered to be a trusted position.
41. On 7 February 2022, a mental health and SMS practitioner visited Mr Tabone. She told us that at that time she was working on Guided Self Help (GSH) materials with prisoners on behalf of the mental health team. She said that there were three GSH workbooks which prisoners completed themselves and that she guided them through this process. She recorded that Mr Tabone was keeping himself busy and was receiving support from his son and daughter, whom he telephoned twice a week.
42. On 17 February, Mr Tabone was sentenced to five years imprisonment for conspiracy to supply class A drugs. Staff spoke with Mr Tabone when he returned from court to check on his well-being. Mr Tabone did not raise any concerns.
43. On 27 February, Mr Tabone went to work in the CSU. When he arrived, prison staff completed a routine search. They asked him to empty his pockets and when he did so, he had a medication bag with another prisoner's name on it, which contained a single Ibuprofen tablet. Staff asked him about the tablet and where it came from. He said that another prisoner had given it to him the night before because he was in pain. Prison staff sent Mr Tabone back to L wing and placed him on report. The next day, Mr Tabone attended a prison disciplinary hearing (known as an adjudication). He pleaded guilty to having medication belonging to another prisoner. The adjudication manager reminded him of the prison rules but decided not to take any further action, and because of Mr Tabone's previous good behaviour, he was allowed to keep his job in the CSU.
44. On 8 March, a prisoner asked Mr Tabone to pass an item to another prisoner who was being held in the CSU. Mr Tabone refused. As a result, prisoners on the unit verbally abused him, but CSU staff praised and commended him for his actions.
45. On 19 March, a SMS practitioner visited Mr Tabone in the CSU while he was working. She recorded that he was happy and that he planned to return to Sicily on his release from prison and intended to work with a family friend. He said that he had no thoughts of self-harm and knew where to get support should he need it. On 2 April, she visited Mr Tabone again. Mr Tabone talked about plans after his release and told her that he did not intend to return to illicit drug use after his release.
46. On the 10 April, Mr Tabone decided to stop taking his antidepressant medication and on 13 April, IHBT discharged him from their services. The IHBT did not

reassess his needs following his decision or refer him to a mental health nurse or GP for review as they should have done.

Events of 27 and 28 June

47. On 27 June, Mr Tabone attended work in the CSU as usual. He returned to L wing at around 6.00pm. CCTV showed Mr Tabone arriving back onto the wing; all other prisoners were locked in their cells. Mr Tabone walked around the landing and stopped at a couple of cells to speak to other prisoners through their cell door. He then collected his meal and had a shower before staff locked him in his cell at approximately 7.00pm.
48. At approximately 7.40pm, an OSG arrived on L wing to start the night shift. He said that when he arrived on the wing, two members of staff that had been on the 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.
49. 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 7.40pm 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. He had no reason to check on Mr Tabone during the night.
50. At 5.06am on 28 June, the OSG began completing a morning roll check on L wing. CCTV shows him arriving at Mr Tabone's cell. The observation panel on the cell door was blocked from inside so he did not have a clear view into the cell however, he thought he could see Mr Tabone lying on the cell floor. He spent around three minutes trying to get a response from Mr Tabone. At interview, he confirmed that Mr Tabone did not respond. He continued along the landing to complete his roll check.
51. At 5.20am, once he had finished checking the rest of the wing, he went back to the wing office and called a Custodial Manager (CM), the most senior officer in charge at that time. He told her that he had been unable to get a response from Mr Tabone, that his observation panel was partially covered, and that he thought Mr Tabone was lying on the floor. She said that she would attend the cell with other staff. CCTV showed an officer arrived at the cell. He and the OSG can be seen looking into Mr Tabone's cell through the observation panel, before walking away. They returned a few minutes later with the CM and another officer.
52. The CM went into the cell followed by the other staff. They found Mr Tabone lying face down on the cell floor. The CM said that due to Mr Tabone's appearance (obvious signs of rigor mortis), it was clear to her that Mr Tabone had been dead for some time and that any attempts to resuscitate him would have been futile. She radioed nursing staff to attend the cell. While in the cell, staff found drug paraphernalia (burnt rolled up tin foil) and considered that Mr Tabone's death might have been drug related.

53. At 5.30am, control room staff called an ambulance and at 5.48am, paramedics arrived at the prison and attended Mr Tabone's cell. After carrying out their own observations, they confirmed that Mr Tabone had died.

Contact with Mr Tabone's family

54. Following Mr Tabone's death HMP Lewes appointed a family liaison officer (FLO). At 10.00am on 28 June, the FLO, along with a prison chaplain, visited Mr Tabone's son at his home to inform him of his father's death. The FLO remained in contact with the family to help arrange the return of property and to offer continued support.
55. The prison contributed to the funeral expenses in line with national policy.

Support for prisoners and staff

56. After Mr Tabone's 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.
57. The prison posted notices informing other prisoners of Mr Tabone's 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.
58. Prison staff acted on intelligence and carried out searches to identify further illicit items on the wing. They also liaised with local police and Public Health England and provided advice to prisoners on the dangers of using isotonitazene.

Post-mortem report

59. The post-mortem report gave Mr Tabone's cause of death as isotonitazene toxicity.

Information received after Mr Tabone's death

60. A substance misuse worker at Lewes told the investigator that she had not worked directly with Mr Tabone, but that he was employed in the CSU with one of her clients. She told us that she was aware through hearsay that Mr Tabone used illicit substances throughout his previous sentences. She said that every now and again when she did see Mr Tabone, she got the impression from his presentation that he had 'used something' (illicit drugs) and described him as a 'functioning' addict. However, this was only her personal view and not based on any evidence and she did not raise her views with anyone else. No one else interviewed as part of this investigation shared any knowledge or concerns that Mr Tabone had used drugs during his most recent sentence.

Findings

Assessment of Mr Tabone's risk and substance misuse

61. Mr Tabone had been in prison before and was known to staff at Lewes. He had been convicted of supplying heroin and cocaine, was a known drug user and had been taking illicit drugs since the age of 17.
62. When he arrived at Lewes in October 2021, he was identified as withdrawing from illicit substances and was placed on a methadone detoxification programme. However, Mr Tabone declined any further involvement with SMS and said that he intended to remain drug free. Staff did not raise any concerns about Mr Tabone being under the influence of illicit substances, and there was no intelligence information to indicate that he had been involved in the supply or use of illicit substances during his time at Lewes.
63. On 27 February 2022, during a routine search at work, Mr Tabone was found with an ibuprofen tablet that belonged to another prisoner. Staff placed him on report for breaching the prison rules, but staff did not raise any other issues or concerns about his conduct or behaviour again. We do not consider that this one isolated incident was sufficient to have indicated that Mr Tabone was involved in drug use or supply at Lewes. In the absence of any clear indications that he was using drugs, we do not think that staff could reasonably have taken any action. We make no recommendation.

Drug strategy at HMP Lewes

64. It is troubling that Mr Tabone was the first of two prisoners to die on the same day from using the same rare synthetic opioid at Lewes. The use of synthetic opioids 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 Tabone's death is an example of the dangers of illicit drugs and illustrates why prisons must do all they can to eradicate its use.
65. In April 2019, HM Prison and Probation Service (HMPPS) issued a national instruction that all prisons should review their drug strategies. The 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.
66. 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.

67. 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 Tabone took prior to his death.
68. 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 Tabone 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.

Roll checks

69. 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.
70. The Local Security Strategy (LSS) at HMP 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.
71. 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.
72. Because the OSG did not complete two roll checks, it would appear that Mr Tabone was last seen alive at 7.00pm. We do not know whether the OSG conducting the

two evening roll checks would have made any difference to the outcome for Mr Tabone, but roll checks are important for both prisoner safety and security.

73. 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.
74. We make the following recommendations:

The Governor should ensure that all staff understand 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.

Cell observation panels

75. Lewes does not have a local policy advising staff what to do if they find a cell observation panel obscured. A HMPPS Safety Briefing on observation panels, issued in February 2018, states that when staff discover that a panel has been blocked, and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare. In such circumstances, we would usually expect staff who cannot see or speak to a prisoner to radio for help from other staff and remain at the cell door. If they believe the prisoner may be at risk, they should assess the risk of opening the cell door before help arrives.
76. After first identifying that Mr Tabone's observation panel was blocked, not receiving a response, and believing that he could see Mr Tabone lying on the cell floor, the OSG continued his count of prisoners before returning to the wing office. He telephoned the CM and asked her to come over and check on Mr Tabone. Mr Tabone's cell was only opened when the staff arrived, over 15 minutes after the OSG had first discovered the blocked observation panel.
77. We consider that the OSG should have taken action to ensure that Mr Tabone's cell observation panel was clear, including calling the CM on his radio, opening the cell to remove the blockage and check on Mr Tabone's welfare and calling a medical emergency if necessary. Although it is unlikely that earlier intervention would have changed the outcome for Mr Tabone, such actions could prove crucial in similar situations.
78. In a previous investigation into the death of a prisoner at Lewes in May 2021, prison staff told us that it was not unusual for prisoners to block their observation panels at night and up to 16 cells on the wing could have their panel blocked on any one night. We observed that it appeared that the culture at Lewes, where prisoners frequently block their observation panels with little consequence, contributed to staff's decision not to take more urgent action. We recommended that prisoners who blocked their observation panels were challenged, blockages were removed, and frequent offenders received appropriate disciplinary action or support, and that staff were made aware of the national guidance and understood their responsibilities when they found a cell observation panel obscured. The prison accepted our recommendation and provided us with an action plan which said that

in February 2022, a Notice to Staff (NTS) was issued. However, during the course of this investigation, the prison told us that the NTS was not published because it was decided that something more robust was needed. At the time of Mr Tabone's death in June 2022, Lewes still had no local policy in place.

79. The Head of Safety at Lewes told us that the Safety Committee wanted to ensure that new starters and staff always had access to Safety information, and it was decided that a Safety Newsletter/handbook would be designed and distributed. She said that this had not happened when she took over the role in September 2022, but that she had completed the document in October, and it was ready for issue. We repeat our previous recommendation:

The Governor should ensure that:

- **prisoners who block their observation panels are challenged, blockages are removed, and frequent offenders receive appropriate disciplinary action or support; and**
- **staff are aware of national guidance and understand their responsibilities when they find a cell observation panel obscured.**
- **they confirm with the PPO that that the Safety Newsletter/handbook has been issued and the date this was completed.**

Clinical care

80. The clinical reviewer concluded that the clinical care Mr Tabone received at Lewes was not equivalent to that which he could have expected to receive in the community.
81. She was concerned about substance misuse and mental health care given to Mr Tabone. On his arrival at Lewes on 21 October 2021, a SMS assessed his substance misuse needs. She checked him for any withdrawal symptoms and, as the Clinical Opiate Withdrawal Scale (COWS) score did not give any cause for concern, this action plan was appropriate at the time. However, the clinical reviewer found that there was no evidence that healthcare staff completed any follow up COWS assessments or arranged any appointments with the prison's Substance Misuse Services. She considered that healthcare staff should have completed a further needs assessment for continuation of care but that they failed to do so. We recommend:

The Head of Healthcare and the Head of the Substance Misuse Service should ensure that healthcare staff:

- **complete follow up COWS assessments and appointments for prisoners who have previously displayed substance misuse withdrawal symptoms, to ensure continuity of care; and**
- **record documentation relating to clinical rationale in the prisoner's medical record.**

82. Mr Tabone was appropriately referred to IHBT. He was discharged from the service on 13 April 2022. Medical records indicated that he completed the workbooks as part of his treatment and support. However, he stopped taking his antidepressant medication on 10 April. The clinical reviewer was concerned that, while there was no evidence in Mr Tabone's medical records that stopping his antidepressant medication had any adverse effects on his mental health, IHBT did not offer a further mental health assessment to assess his needs or arrange a follow up appointment with a mental health nurse or GP as they should have done. The clinical reviewer made two recommendations about these issues which we do not repeat in this report, but which the Head of Healthcare and the Head of the Mental Health Team will need to address.

**Prisons &
Probation**

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