Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 HM Prison and Probation Service**
1	**CORONER** I am Michael Spencer, Assistant Coroner for the coroner area of East Sussex.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 01 July 2022, I commenced an investigation into the deaths of Giuseppe TABONE aged 58 and Andrew EVANS, aged 34, who both died on 28 June 2022 in HMP Lewes. The investigation concluded at the end of the joint inquest into their deaths on 26 February 2024. The conclusion of the inquest was that: Andrew Evans and Giuseppe 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. There were admitted failures by Prison staff to carry out roll checks at 19.30 and 20.45 on 27th June 2022. It is not possible to say whether had those checks been carried out their lives would have been saved. Isotonitazene had not been encountered in prison before therefore had the anit-drug Naloxone been administered it may not have been effective as a normal single dose is used but for isotonitazene multiple doses may be needed.
4	**CIRCUMSTANCES OF THE DEATH** Giuseppe and Andrew died from the intentional inhalation of isotonitazene at HMP Lewes. [redacted] Clinical evidence of the onset of death is inconclusive but suggests it is likely that Giuseppe and Andrew fell unconscious shortly after inhaling the substance.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) At the inquest, two prison staff admitted that they had independently failed to carry out the required roll checks on L wing at 7.30pm and 8.45pm on the evening of 27 June 2022. One officer recorded on the wing log book that he had carried out the 7.30pm check, even though he did not do so. The other gave evidence that he did not carry out the 8.45pm check because he was distracted by the day shift officers, who were watching videos in the

	control room and were not responding to prisoner's cell bell calls. The staff members concerned have been subject to disciplinary proceedings, but continue to work at the prison. It was not possible to say on the evidence whether Andrew or Giuseppe's lives could have been saved had the required roll checks been carried out. Evidence was given that, since this incident, staff have been provided with 'bite size' training on roll checks, although neither of the staff members concerned had received this training. I remain concerned that there is a risk of future deaths caused by prison staff at HMP Lewes failing to carry out the required checks on prisoners, particularly during the night state. The purpose of roll checks is to ensure that each prisoner is present and alive and well. If a roll check is not carried out, there is a risk that a prisoner in need of medical attention and unable to ring the cell bell could remain undiscovered until the morning. There was confusion from staff at the prison as to when full roll checks are required. Further, I am concerned that staff may know when roll checks are required but not fully understand the importance of carrying out every required check. Both staff members concerned were aware that the roll check was required, but did not carry it out because they thought that checks had been carried out by other staff members. I am also concerned that there are insufficient measures in place to monitor staff to ensure that all required checks are being carried out. There may be lessons that can be learnt from other prisons as to how to ensure checks are always carried out.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by May 7, 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons **Practice Plus Group** **The family of Giuseppe Tabone** **The family of Andrew Evans** I have also sent it to **HM Inspectorate of Prisons** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.

	You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 12/03/2024**  **Michael SPENCER** **Assistant Coroner for** **East Sussex**