Her Majesty's Coroner
Staffordshire (South) Coroner's Jurisdiction

Date: 15 January 2021

Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Director General of Prisons

1 **CORONER**

I am Mr Andrew A Haigh Senior Coroner for Staffordshire South

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3 **INVESTIGATION and INQUEST**

On 27 December 2017 I commenced an investigation into the death of Kevin John LOVATT. The investigation concluded at the end of the inquest on 14 January 2021. The conclusion of the inquest was accident with the cause of Kevin's death being obstruction of the internal airways with close temporal relationship to restrain

4 **CIRCUMSTANCES OF THE DEATH**

a) Kevin was a serving prisoner at HMP Dovegate. He died at prison on 22.12.17 having swallowed a package of illicit drugs on which he choked.
b) Probable causative issues
The deliberate swallowing of too large a package of illicit drugs
c) Possible causative issues
i) Communication
It was not communicated to officers that Kevin had something in his mouth prior to handcuffs being applied.
Code Blue was not sounded immediately it was noted Kevin was choking.
No one person on the scene took immediate control leading to too many people in a confined space and consequent confusion.
ii) Vomiting may have had an additional causative effect.
iii) Lack of ALS trained staff who had access to forceps.
iv) The use of fingers in the throat in an attempt to remove the obstruction contrary to accepted

practice (but heavily caveated by the fact that Kevin may already have been dead and the fact that those involved were desperately trying to save his life).
v) Insufficient training to ensure that medical staff were put in a position where they could make an immediate medical assessment.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTER OF CONCERN** for you is as follows. –

Following the investigation by the Prisons and Probation Ombudsman a recommendation was made that you should ensure that there is clear guidance and training on the safe use of force when resistant prisoners have items in their mouth which might compromise their breathing. In evidence at the inquest I heard that suitable training on this topic did not appear to have been delivered and that it would be appreciated by prison staff. I wonder therefore if the national training you provide could include control and restraint for prisoners with items in their mouths.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 12 March 2021. 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:
Tuckers Solicitors who represent Kevin's family
DWF Law who represent Serco who manage HMP Dovegate
Practice Plus Group (formerly Care UK) who provide healthcare at HMP Dovegate
I have also sent it to the Prisons and Probation Ombudsman and to the Independent Monitoring Board for HMP Dovegate who may find it useful or of interest.
I am also under a duty to send the Chief Coroner a copy of your response.
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.

15 January 2021

Andrew Haigh Senior Coroner for Staffordshire South

1 Staffordshire Place, Stafford, ST16 2LP
Telephone: 01785 276126 or 276127 Email: sscor@staffordshire.gov.uk

Her Majesty's Coroner
Staffordshire (South) Coroner's Jurisdiction

Date: 15 January 2021

Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: NHS England Health and Justice Regional Team Chair [redacted]

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I am Mr Andrew A Haigh Senior Coroner for Staffordshire South

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The **MATTER OF CONCERN** for you is as follows. –

During evidence at the inquest I heard that nursing staff at HMP Dovegate (and throughout the prison estate) are trained to an Intermediate Life Support level. I realise it would be impractical for all nursing staff at prisons to be trained to an Advanced Life Support level however I was informed that at some stage there was at least one paramedic employed at HMP Dovegate who was trained to ALS level. I wonder if there might be some limited provision of ALS trained staff in the prison estate and if this could be part of the appropriate commissioning arrangements.

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15 January 2021

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