REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Ben Wallace MP, Secretary of State for Defence, Ministry of Defence, Whitehall, London SW1A 2HB**
1	**CORONER** I am Mr D M Salter, Senior Coroner, for the Coroner area of Oxfordshire
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 23rd June 2021 at Oxford Coroner's Court I conducted the inquest into the tragic death of Cpl Ryan Lovatt in Warsaw in the early hours of 1st August 2019 when he fell from his hotel balcony. I returned a conclusion of Accident and found as follows; *Cpl Ryan Lovatt was based in Poland and on an organised cultural visit with army colleagues to Warsaw on 31st July 2019 and 1st August 2019. He was drinking heavily on the evening of 31st July 2019 and early hours of 1st August 2019 and was intoxicated with alcohol but also pepper sprayed by a bouncer on leaving a club. He was put to bed by a colleague in his 7th floor room in the City Comfort hotel but subsequently fell, accidently and unwitnessed, from the balcony of his room to his death.* Cpl Lovatt's family attended the inquest. They were represented by Counsel, [redacted]. The MOD were also represented by Counsel, [redacted]. A number of witnesses attended (remotely) to give oral evidence. This included friends and colleagues of Cpl Lovatt who were out with him on the night in question.
4	**CIRCUMSTANCES OF THE DEATH** As will be seen from the above, Cpl Lovatt fell accidentally to his death at a time when he was intoxicated with alcohol. The fall was unwitnessed. There was no evidence of suspicious circumstances or third-party involvement and no evidence that this was an intentional act on his part. Cpl Lovatt was part of a small group of soldiers on what was an organised cultural trip to Warsaw. Following the schedule of trips during the day, he and the others went to their hotel to prepare for a night out. Some went for a meal and returned quite early to the hotel but the others including Cpl Lovatt went drinking in bars/clubs until, it seems, the early hours. It is clear that this involved heavy drinking and drunkenness. There were two incidents outside clubs where some members of the group were pepper sprayed by door staff but, on the evidence I heard, this appeared to be unprovoked and heavy handed. Cpl Lovatt was pepper sprayed during the second incident and returned to the hotel in a taxi with a colleague who took him to his room. A short time later the accident occurred.

	I heard evidence about Op Cabrit and a force protection policy with regard to drinking alcohol, Annexe E, and the extension of the normal 2 can rule to 4 cans on cultural trips such as this one. I also heard evidence about curfews and a stipulation that a member of the group should be appointed as 'shark watch' with the responsibility of remaining sober and being in a supervisory capacity. It was clear however from the evidence I heard from the soldiers that this system was not well understood and not complied with.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to a 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 **MATTER OF CONCERN** is as follows. – I am concerned about whether the existing alcohol policy is fit for purpose and whether there are systemic failures in respect of it. According to the Learning account, I understand the policy was reviewed as a result of this tragic incident and deemed to be appropriate. I understand that Op Cabrit is unusual in that it is a formal operation but one that is within allied nations. I note from the Learning Account that there is an emphasis on normalising the deployment to make it appealing to soldiers to re-deploy for a second time. I also understand though that the facilities at the camp where Cpl Lovatt was based in Poland left a lot to be desired and morale was not high. There is what appears to be a fairly restrictive alcohol policy, the 2 can rule. The deployment appears to sit somewhere between an operational tour and being normalised. The result of this appears to be a systemic problem with regard to understanding the policy and complying with it. It is possible that a restrictive alcohol policy and poor conditions in the base might lead to excessive/binge drinking when on a trip such as this one. Rather than tightening the policy, it is possible that less restrictive conditions at the base is part of the answer. Whichever view is taken of the above, whether it is a 2 can rule, 4 can rule or more, an important safeguard is the requirement for a soldier, normally an NCO, to be nominated as shark watch and to remain sober and vigilant. It is a well known and common sense concept. It is not clear to me if there is a formalised policy. I anticipate the system may operate differently depending on the personnel and location. In this case, the system did not operate effectively as the person nominated as shark watch did not appear to know that he had been nominated. Others who gave evidence were unclear about the existence or requirements of such a system. In short, my concern is that there is not a realistic, workable, or widely understood policy that is capable of being enforced with regard to alcohol on Op Cabrit and that, furthermore, the role of shark watch is not given greater prominence.
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 27 September 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 family. 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 other 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.
9	 **03 August 2021**