REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care** **2. Director General Chief Executive Officer of His Majesty's Prison and Probation Service (HMPPS)**
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
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 4th November 2022, I commenced an investigation into the death of Colin David Lovett, born on the 26th February 1969 who was aged 53 years at the time of his death. The investigation concluded at the end of the Inquest before a jury on the 28th May 2025. The medical cause of death was: Ia Insulin overdosage II Hypertensive and Ischaemic Heart Disease The conclusion of the Inquest was: Suicide – We The Jury believes that there were contributory factors related to Colin's suicide as follows: 1. The decision of the monitoring of the telephone calls Colin made following the review on the 11th October 2022 and the lack of the monitoring of Colin's telephone calls after the 11th October 2022 probably contributed more than minimally to his death. 2. Colin's access to medication in his cell possibly contributed more than minimally to his death. 3. The inadequacy of Colin's risk management and support at HMP The Verne possibly contributed more than minimally to his death.

4	**CIRCUMSTANCES OF THE DEATH** On the 29th October 2022 Colin, who was diagnosed with Type 1 Diabetes in 1989 for which he was insulin dependent, was found in a collapsed and unresponsive condition in his room, Room 5 on Wing B1 at HMP the Verne, Portland Dorset.
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 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. – (1) Evidence was provided by the Prison Service staff during the Inquest that they have never received training about diabetes and there is a lack of understanding, and national guidance for Prison Service staff relating to the symptoms of a hypo glycaemic or hyper glycaemic attack, which can be fatal. (2) The healthcare department at HMP The Verne is only operated between 7.30am and 6pm daily and is not therefore available 24 hours a day. Outside of these operational times, access to healthcare would be via 111 or 999 which could cause delay in action being taken to resolve a hypo glycaemic or hyper glycaemic attack. This will be the position in other prisons nationally. (3) Whilst insulin dependent diabetics are likely to be experts in their own care, some prisoners may have poorly managed diabetes and require support which could be at any time. (4) It is acknowledged that there is a balance to be stuck with training non-medical individuals in diagnosing medical symptoms, which could lead to miss diagnosis, and ensuring care is provided without delay, however the Head of Healthcare at HMP the Verne stated that there would be benefit in providing an awareness to Prison Service staff of the impact on prisoners of long term conditions such as diabetes. (5) Several members of Prison Service staff gave evidence at the Inquest and only one, who had personal experience through a family member, had an understanding of diabetes and the impact it can have upon an individual, including the symptoms of a hypo glycaemic or hyper glycaemic attack. (6) Prisoners are dependent upon support provided by Prison Staff. I am concerned that the lack of awareness of the needs of prisoners with insulin dependent diabetes amongst Prison Service staff who provide care to prisoners at times when healthcare staff are not on site, could lead to future deaths. . (7) Although the evidence was based on the position at HMP The Verne, I am concerned this could be apply to other prisons nationally.

“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 25th July 2025. 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 via their legal representatives: (1) Colin’s Family (2) HMP the Verne (3) The Ministry of Justice (4) Practice Plus Group (PPG) (5) Oxleas NHS Foundation Trust (6) Dorset County Hospital NHS Foundation Trust I am also under a duty to send the Chief Coroner a copy of your response. I have also sent the report to Diabetes UK who I believe will be interested in the contents of the report. 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	**Signed**  **Rachael C Griffin** **HM Senior Coroner for Dorset** **30th May 2025**