Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Lovett, a prisoner at HMP The Verne, on 29 October 2022

A report by the Prisons and Probation Ombudsman

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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

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Colin Lovett died from an intentional insulin overdose on 29 October 2022 at HMP The Verne. He was 53 years old. I offer my condolences to Mr Lovett's family and friends.

Mr Lovett had risk factors for suicide and had attempted suicide by insulin overdose in the community. The clinical reviewer has concluded that the decision to allow Mr Lovett to keep his insulin in his cell was reasonable, but the risk assessment and assurance process was not sufficiently robust.

Mr Lovett was not subject to suicide and self-harm monitoring while at The Verne. While there were some signs, at times, that he was struggling to cope, the investigation found that staff did not have sufficient information in the days before he died to consider him at high risk of suicide.

HM Chief Inspector of Prisons found that The Verne was a safe prison with low levels of violence and self-harm. Mr Lovett's was the first self-inflicted death at the prison since 2010.

The clinical reviewer concluded that, overall, the care Mr Lovett received at The Verne was generally equivalent to what he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **March 2024**

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Summary

Events

1. On 4 February 2022, Mr Colin Lovett was sentenced to three and a half years in prison for sexual offences and was sent to HMP Winchester.

2. Mr Lovett had a number of chronic health conditions, including type 1 diabetes. His condition caused him to have mobility issues and he later became immobile. As a result, he used a wheelchair to help him get around.

3. Prior to his conviction, Mr Lovett had attempted suicide by various means, including by taking an overdose of his prescribed insulin. He had been sectioned under the Mental Health Act on three occasions.

4. When he arrived at Winchester, staff placed Mr Lovett on suicide and self-harm monitoring procedures known as ACCT because of his recent suicide attempt in the community. He remained on ACCT monitoring until 7 March. Mr Lovett was not allowed to keep his medication in his cell and had to collect it daily from healthcare staff.

5. On 15 March, Mr Lovett was transferred to HMP The Verne. When he arrived, a multidisciplinary review agreed that due to his dietary habits, he would be allowed to keep a supply of insulin in his cell to help him manage his condition better. Mr Lovett was considered to be a difficult patient to manage, often not taking advice from specialists and nursing staff about his condition.

6. Mr Lovett's wife telephoned the prison several times to raise concerns about Mr Lovett's well-being. Staff spoke to him on each occasion, and he told them that he had no thoughts of suicide or self-harm. Mr Lovett was not subject to ACCT monitoring during his time at The Verne.

7. Mr Lovett sometimes displayed challenging behaviour. Staff managed him using a Challenge, Support, Intervention Plan (CSIP). The plan provided him additional support to manage his anger, behaviour and medical needs. Mr Lovett's behaviour improved.

8. On 11 October, Mr Lovett was granted level three contact with his children. This meant that he was able to speak to them over the telephone, but the calls should have been subject to staff monitoring. The application was not actioned prior to his death so staff were not monitoring his calls in the days leading to his death.

9. On 27 October, during a routine check, Mr Lovett was tearful. He told staff that he did not have any telephone credit to speak to his children. He later told staff that he did have credit and had spoken to his family. Mr Lovett said that he was all right and that he had no thoughts or intent to self-harm. However, during the calls to his wife that evening, Mr Lovett said that he intended to take his own life by insulin overdose and told her that he had given assurances to staff that he would not.

10. At 8.50 on 29 October, staff went to tell Mr Lovett that he had a video call with his wife at 9.00am. When they entered his room, there were clear signs that Mr Lovett was dead. Staff radioed a medical emergency code and prison and nursing staff

attended. It was clear to healthcare staff that any attempts at resuscitation would not be successful. At 9.20am, it was confirmed that Mr Lovett had died.

11. Staff found a suicide note and a used insulin pen beside his bed.

Findings

12. Mr Lovett had a number of risk factors for suicide, including a previous intentional overdose of his insulin in the community. While at The Verne, there were some indications that he was struggling to cope, including that he was sometimes upset and in September, he told the psychiatrist that he thought about suicide. In the days before his death, he told his wife that he was thinking of killing himself by overdosing on his insulin. However, prison staff looking after him were unaware, and we do not think that they had sufficient information to consider him at high risk of suicide at that time, or to begin ACCT monitoring.

13. The clinical reviewer concluded that the clinical care Mr Lovett received at The Verne was generally of a reasonable standard and equivalent to what he could have expected to receive in the community. She was, however, concerned about aspects of Mr Lovett's diabetes management, including the management of his in-possession insulin and concluded that this aspect of his care was not equivalent.

Recommendations

- The Head of Healthcare should ensure that:
    - blood glucose levels are taken at reception for all diabetics and those with a Freestyle Libre sensor and ensure the readings are recorded in the prisoner's medical record at reception,
    - there is a system in place to monitor use of glucose tablets and overuse should prompt a diabetic medication review; and
    - there is an in-possession policy in place, to identify whether a prisoner is able to have weekly or monthly prescriptions in possession which includes vigorous risk assessment, compliance monitoring with the medication regime and random cell checks to count medications.

The Investigation Process

14. HMPPS notified us of Mr Lovett's death on 29 October 2022.

15. The investigator issued notices to staff and prisoners at HMP The Verne informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Lovett's prison and medical records.

17. The investigator interviewed ten members of staff at The Verne on 30 November 2022, and 26 and 27 January 2023.

18. NHS England commissioned a clinical reviewer to review Mr Lovett's clinical care at the prison. He and the investigator jointly interviewed healthcare staff.

19. We informed HM Coroner for Dorset of the investigation. The investigation was suspended between May and November 2023 while we awaited confirmation of the cause of death. We have sent the Coroner a copy of this report.

20. The Ombudsman's family liaison officer contacted Mr Lovett's wife to explain the investigation and to ask if she had any matters, she wanted us to consider. Mrs Lovett had concerns about her husband's physical and mental health and the treatment he received. These matters have been addressed in the clinical review report.

21. HMPPS responded to our initial report on 26 March 2024 indicating no factual inaccuracies. The recommendations made were fully accepted.

22. Legal representatives for Mr Lovett's wife responded to the initial report on 21 March 2024 and requested information to be added to the final report. The additional information is added at paragraphs 65 and 66. No factual inaccuracies were highlighted.

23. An inquest was held and concluded on 28 May 2025. Mr Lovett was considered to have died as a result of suicide by way of insulin overdose.

Background Information

HMP The Verne

24. HMP The Verne is a male category C training prison, for those convicted of sexual offences.

25. Care UK provide healthcare services at The Verne with primary care staff available from 7.30am to 6.00pm every day. Outside of these hours, medical care is provided by either emergency services, or the NHS 111 telephone line for health advice depending on need.

HM Inspectorate of Prisons

26. The most recent inspection of HMP The Verne was in February 2020. Inspectors reported that in general, The Verne was a safe prison with low levels of violence and self-harm. Healthcare provision was less positive. The inspectors said that it had taken too long for NHS commissioners to carry out a health needs assessment of the population. As a result, the health services team was under-resourced and was unable to meet the needs of the population.

27. Inspectors found that prisoners were never locked in their rooms and had free access around the site for over nine hours a day, but there was not enough activity to occupy all prisoners. In addition, the education curriculum did not meet the needs of the population, which meant that too many prisoners were unemployed at the time of the inspection.

Independent Monitoring Board

28. 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 July 2022, the IMB reported that there were four deaths during the reporting year, all of which were from natural causes. The Board said that it believed that, when compared with NHS healthcare in the wider community, the service at The Verne was of a consistently high standard.

Previous deaths at HMP The Verne

29. Mr Lovett was the fourteenth prisoner to die at The Verne since August 2020. Of the previous deaths, 12 were from natural causes and one is awaiting classification. Mr Lovett's death was the first self-inflicted death at The Verne since April 2010. There were no similarities between Mr Lovett's death and the previous investigations.

Assessment, Care in Custody and Teamwork (ACCT)

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an

initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Challenge, Support, and Intervention Plan (CSIP)

31. CSIP provides a framework for managing violence, centred around the individual and their specific needs, used across the adult prisoner estate. It is aimed at those prisoners who display challenging and violent behaviours.

Key Events

32. On 4 February 2022, Mr Colin Lovett was sentenced to three and a half years in prison for sexual offences. He was sent to HMP Winchester. This was Mr Lovett's first time in prison.

33. Mr Lovett had a significant medical history which included: type 1 diabetes mellitus, diabetic maculopathy (damage to the eyes caused by diabetes), coeliac disease (a digestive disorder), ischaemic heart disease and hypertension (high blood pressure). Mr Lovett had been under the care of a range of community consultants for management of his long-term conditions. He also had a history of poor mental health and suicide attempts.

HMP Winchester

34. On Mr Lovett's arrival at Winchester, a nurse completed his reception health screen. She noted Mr Lovett's medical conditions and mobility issues. He took appropriate medications for his long-term conditions, including insulin to manage his diabetes, blood pressure medication and later antidepressant medication.

35. The nurse recorded that Mr Lovett was low in mood and tearful. She noted that he had been sectioned under the Mental Health Act in the community three times. Mr Lovett said he had current thoughts of self-harm and had a history of depression. Mr Lovett had attempted suicide in the community on three occasions in January 2022. On the third occasion, on 31 January, he had taken an overdose of his insulin. As a result, staff decided that Mr Lovett would not be allowed to keep his medication with him in his cell and instead would need to collect it daily and take it in front of healthcare staff. Staff placed Mr Lovett on suicide and self-harm monitoring (known as ACCT) and observed him hourly. He engaged with the prison's Mental Health Team during his time at Winchester.

36. Staff held a multi-disciplinary ACCT review and noted that Mr Lovett was finding it difficult to come to terms with being in prison. He said that prior to his court hearing, he had been told that he was likely to receive a community service order and was shocked when he received a prison sentence. Staff advised him to keep himself busy, and Mr Lovett said that he would apply for work or education to maximise his time out of his cell. Staff reviewed his level of observations regularly which remained between one and two observations every hour.

37. Mr Lovett took time to settle into prison, which was made more difficult because of his healthcare needs. During an ACCT review on 7 March, Mr Lovett said that he was 'in a better place', had received a visit from his wife and had spoken to staff from the offender management unit (OMU) about a transfer to The Verne so that he could be closer to his family. The multi-disciplinary team decided to stop ACCT monitoring.

38. On 15 March, a GP at Winchester saw Mr Lovett. She noted that he appeared in a much better place mentally, and that he had accepted his situation. The GP and Mr Lovett discussed his diabetes management. They noted that his blood sugar control was not as good as it could be, and that his glucose levels dipped during the day and were high at night. Mr Lovett said that he would normally regulate his insulin

depending on what he ate but said that he did not eat regular meals. The GP told Mr Lovett that although there had been concerns about him having his medication in his cell, she would discuss the possibility of this with the healthcare team.

39. That day, Mr Lovett was transferred to The Verne.

HMP The Verne

40. On his arrival at The Verne, a nurse completed an initial health screen. The nurse noted Mr Lovett's medical history but did not refer him to the long-term conditions clinic or create care plans to manage his long-term conditions. All his clinical observations were normal, but the nurse did not record his blood glucose reading as she should have done. The nurse referred Mr Lovett to the GP for further review and to the mental health team.

41. The nurse noted Mr Lovett's history of suicide attempts and that Mr Lovett had been monitored under ACCT procedures at Winchester. The nurse asked Mr Lovett about his previous suicide attempts and about being subject to ACCT monitoring at Winchester. Mr Lovett said that he had been very depressed when he was sentenced and when he first arrived in prison, but that he was unlikely to feel that way at The Verne. Mr Lovett said that he had no thoughts of suicide or self-harm. The nurse noted that Mr Lovett should not keep his medication with him in his cell, but that he needed a medication review. His medication was reviewed later that day.

42. That day, a Supervising Officer (SO) recorded that Mr Lovett's ACCT post-closure interview had not been completed before he left Winchester. The SO arranged for it to take place the following day, and Mr Lovett would be observed overnight as part of the standard first night procedures.

43. At the ACCT post-closure interview on 16 March, Mr Lovett said that he felt settled since having contact with his wife and that The Verne felt like a more settled environment. He was happy to be there because the prison was closer for his wife to visit. Mr Lovett said that he understood all the support and help on offer and that he knew where to go if he felt vulnerable again. Mr Lovett was looking forwards and was planning to use his time constructively.

44. The next day, a mental health nurse saw Mr Lovett. They talked about his early life, past poor mental health, self-harm, and his previous suicide attempts. Mr Lovett said that he no longer had thoughts of self-harm and was happier now that he was closer to his family. He said that he had turned a 'massive' corner and felt positive about the future. Mr Lovett told her that he did not need support from the mental health team at that time. She recorded that she had prescribed Mr Lovett with antidepressants and referred him to the depression clinic.

45. On 18 March, a nurse saw Mr Lovett for a follow up physical health review. Mr Lovett was in good spirits and said that he had made a mistake by taking the overdose in the community and wanted to get home to his family. She discussed Mr Lovett's care with the healthcare team. She recorded that healthcare staff would see Mr Lovett daily to ensure that his mental well-being was not deteriorating.

46. The Head of Healthcare at The Verne told the investigator that Mr Lovett needed access to his insulin outside of healthcare hours due to his eating habits, and it was therefore in his best interests for him to keep his insulin in his cell (although he was still expected to collect his other medications from healthcare staff each day). She said that the decision to allow Mr Lovett to keep his insulin in his cell was made at a multidisciplinary team meeting (MDT) in March and the decision was discussed and reviewed at subsequent MDTs. There was little documented evidence of how the MDT balanced the known risk of Mr Lovett keeping insulin in his cell against the benefits to his health. She acknowledged that the quality of record keeping was not as good as it should have been. The MDT concluded that Mr Lovett could keep two insulin pens in his cell at any one time. Each pen contained three doses that he was expected to inject throughout the day according to his blood sugar levels. He was expected to exchange empty pens for a new one at the medication hatch as and when needed. Mr Lovett used a glucose monitoring system (called a Freestyle Libre) which alerted him to changes in his blood sugar levels and helped him to administer his insulin correctly.

47. Mr Lovett told the nurses that he did not usually eat breakfast, and had lunch about 11:30am, so needed insulin between 12.00pm and 1.00pm, and that the evening meal was too early for him, as he ate at around 7.00pm to 8.00pm, and needed insulin after that, when healthcare staff were no longer on duty.

48. Mr Lovett displayed rude and aggressive behaviour towards staff on several occasions. He refused to wear appropriate clothing when he collected his meals and refused to wear a face mask (restrictions were in place due to the COVID-19 pandemic) and said that he was exempt. There was no evidence of the exemption in his community medical records.

49. On 21 March, Mr Lovett's wife telephoned the prison because she was concerned about Mr Lovett's well-being. She had not heard from Mr Lovett since the previous day when he had been upset. Mr Lovett had told his wife that he had been refused food. The information was passed to staff who checked on Mr Lovett. We found no evidence that Mr Lovett was refused food at The Verne.

50. Mr Lovett's wife contacted the prison again on 24 March. She repeated that she had contacted the prison on 21 March about her husband. Later that day, a SO spoke to Mr Lovett's wife about her concerns, and the SO asked healthcare staff to visit Mr Lovett and check his blood sugar in light of his diabetes. A nurse saw Mr Lovett and recorded that Mr Lovett had been eating sweets and glucose tablets to control his blood sugar levels and that she had advised him that this was not appropriate. Healthcare staff told us that Mr Lovett often used glucose tablets to control his insulin levels, despite being told this was inappropriate by nurses and external specialists during hospital visits. He was also referred to a dietician. An entry in the medical record on 18 March indicated that Mr Lovett was experiencing one to two hypoglycaemic (a fall in blood sugar levels below normal) events a week and was overusing glucose tablets to counter these events. Ideally, diabetics should manage their condition with sensible meal plans and adjusting insulin. He had a virtual appointment with the hospital endocrinologist at this time who advised Mr Lovett to reduce the amount of insulin he was injecting to reduce the number of hypoglycaemic events.

51. On 19 April, Mr Lovett attended the medications hatch to collect his morning medications. He asked nursing staff to see him because his right toe was painful, and he believed it was infected. Healthcare staff saw Mr Lovett in the clinic, and they confirmed that his toe was infected and that this was as a result of his ongoing diabetes condition.

52. On 22 April, Mr Lovett attended hospital and underwent an operation to remove his toe. He returned to The Verne on 25 April.

53. On 26 May, Mr Lovett's keyworker introduced himself. Mr Lovett asked him about his contact with his children and the keyworker agreed to contact Mr Lovett's prison offender manager (POM). (At this time, Mr Lovett was not allowed contact with his children.)

54. On 31 May, Mr Lovett attended the diabetes clinic for a follow up appointment following his operation. The consultant was pleased with his progress and encouraged Mr Lovett to walk rather than use a wheelchair. Mr Lovett said that he understood the advice and when he returned to the prison, his wheelchair was returned to the prison's healthcare unit.

55. At the beginning of June, staff issued Mr Lovett with several warnings about his attitude towards staff and compliance with prison rules. They placed Mr Lovett on a basic regime following a review of his incentives and earned privileges (IEP). The IEP scheme has three levels, basic, standard and enhanced. Prisoners are placed on a level depending on their behaviour and the higher the level the increased access to privileges, including time out of cell, access to canteen items and additional visits. Prisoners on basic level have limited privileges, including not having a television in their cell.

56. On 8 June, Mr Lovett's wife telephoned the prison and raised concerns that Mr Lovett was low in mood and said that she was concerned about him. Wing staff spoke to Mr Lovett. He became emotional and said that his cellmate was supporting him. Mr Lovett said he felt staff were picking on him. Staff reassured him and told a SO about Mr Lovett's wife's call and the conversation they had had with Mr Lovett. The SO decided not to start ACCT monitoring procedures at that time. Instead, he placed Mr Lovett on 24-hour monitoring, which was used at The Verne at that time to support prisoners thought to require a period of additional monitoring but not assessed as requiring ACCT monitoring. Unlike the ACCT process, there was no specified frequency of observations set, but an expectation that more frequent welfare checks would be completed during the 24-hour period.

57. Later that afternoon, the keyworker spoke to Mr Lovett. Mr Lovett told him that he was alright, but he felt that staff were bullying him. The keyworker explained to him why staff had placed him on a basic regime. Mr Lovett said that he wanted to move from C2 wing, ideally with his cellmate. The keyworker told him to make an application to the wing manager. He spoke to Mr Lovett again on 15 June. He recorded that earlier that day, Mr Lovett had been placed on report for being verbally abusive to a member of staff. When he asked Mr Lovett about the incident, he told him that he had become angry after he was told that he was not allowed pictures of his children. The keyworker explained that his application for child contact had not yet been agreed and he was not allowed the pictures. Mr Lovett

agreed and said that he was already aware of this. Mr Lovett reported no other issues.

58. On 16 June, Mr Lovett was moved from C2 wing to A2 wing and was allocated a single cell. Staff recorded positive comments about his attitude and behaviour. In July, Mr Lovett was moved back to standard level IEP as his behaviour had improved.

59. At 8.30am on 1 August, Mr Lovett asked an officer for a wheelchair so that he could attend the healthcare unit to collect his medication. The officer refused Mr Lovett's request on the basis that he had been able to walk to collect his medication the previous day. Mr Lovett was unhappy and, shortly after, threw a plastic bin at the officer, (which narrowly missed him) and shouted, 'you can keep your fucking meds'. Mr Lovett was disciplined, placed on report and was downgraded to the basic regime again.

60. At 8.50am that day, Mr Lovett's wife telephoned the prison control room and told staff that she was concerned about Mr Lovett's health. She told them that he was a type 1 diabetic and that he had recently had his toe removed, and the wound was now infected. She said that she was on the verge of calling an ambulance to attend the prison because she felt that staff were not doing enough and had taken Mr Lovett's wheelchair away from him. Prison staff told a SO about the telephone call, and he placed Mr Lovett on 24-hour monitoring again.

61. The SO spoke to Mr Lovett about the call from his wife. The SO recorded that an appointment had been arranged for the healthcare team to see Mr Lovett that afternoon, and that he could have a wheelchair to attend the appointment if needed. The SO spoke to the Head of Healthcare, who confirmed that if Mr Lovett was unable to bear weight, then a wheelchair would be appropriate.

62. Later that afternoon, a nurse and a Registered Mental Health Nurse (RMN) went to see Mr Lovett. Mr Lovett said that he felt he needed a medication review because he was feeling stressed and depressed, he had not seen his children since February and that his application to appeal against his conviction had been turned down. Mr Lovett became tearful and said that he was upset about being placed on a basic regime. They discussed his mobility concerns and acknowledged that he needed to move about and mobilise where possible. Mr Lovett was monitoring his blood sugars appropriately, but he said that he did not eat well because he did not like the quality of the food. He denied any thoughts or intent to harm himself. The RMN explained to Mr Lovett that his concerns about his mental health appeared to be situational and reactive rather than clinical depression.

63. The following day on 2 August, Mr Lovett was escorted to the Care and Separation Unit (CSU) to attend his disciplinary hearing for throwing the bin at the officer. As Mr Lovett was walking to the CSU, he was abusive to the escorting officer and called them a 'brainless idiot'. When he arrived at the CSU, he continued to be disrespectful.

64. Mr Lovett was found guilty and received a punishment of seven days cellular confinement. However, that afternoon, healthcare requested that Mr Lovett attend hospital for his foot to be assessed. After being assessed at hospital, Mr Lovett was admitted so that he could be treated with intravenous antibiotics. Mr Lovett returned

to The Verne on 5 August. Mr Lovett was not taken back to the CSU and was instead taken to B1 wing (because he had thrown the bin at the officer on A2 wing).

65. Due to a continued deterioration in his behaviour, Mr Lovett was placed on a Challenge, Support, and Intervention plan (CSIP, a framework for managing challenging or violent behaviour). Prison staff considered that the CSIP would set targets for Mr Lovett with expected levels of behaviour and what he could expect in return. (Mr Lovett remained on a CSIP until 14 September, during which time there was a clear improvement in his behaviour.)

66. On the morning of 6 August, Mr Lovett's wife emailed a SO. Mr Lovett's wife told the investigation that she had also e-mailed the Governing Governor. She said that she was disgusted that her husband had been located in a 'filthy' cell, had no kettle, no water jug, no needles for his insulin pen, no other medication and only one pillow. She also said that some of his paperwork, including legal mail and letters from his children were damaged or missing and food Mr Lovett had bought from the canteen was missing. Mr Lovett's wife said that her husband needed to go back to A2 wing.

67. The SO was not on duty over the weekend and responded to the email on 8 August. He reassured Mr Lovett's wife that all living areas were clean and equipped and cells were checked before they were occupied. He told her that the prison was doing all they could for Mr Lovett and that prison and nursing staff were trying to ensure that his care needs were being met. He confirmed that he had spoken to Mr Lovett and provided him with additional pillows to make him comfortable. Mr Lovett's wife told the investigation that her husband told her that when the SO went to see him there had also been a manager present who had told him that if his wife continued calling the prison, it could result in Mr Lovett being transferred.

68. On 10 and 22 August, Mr Lovett's wife contacted the prison again because she was concerned about her husband's well-being. On each occasion staff spoke to Mr Lovett and checked on his welfare. He told staff that he had no issues. Staff gave him the opportunity to use an office telephone to call his wife on more than one occasion, but he declined and said that he would speak to her when he had his telephone credit. Mr Lovett and staff did not raise any concerns over the weeks that followed, and he was later moved back to the standard IEP level as his behaviour had improved.

69. On 1 September, a consultant psychiatrist assessed Mr Lovett. He recorded that Mr Lovett had been diagnosed with an adjustment disorder prior to prison. He noted that Mr Lovett had been under the care of the community mental health team and seen by the liaison team in hospital after an overdose on two occasions, had been assessed under the Mental Health Act and taken to a place of safety but had not been detained, and was not considered to be suffering from a serious mental illness.

70. Mr Lovett told the psychiatrist that he had not been taking his sertraline (antidepressant medication) for six weeks, and although he had been collecting them, he had been throwing them away. He said that he had not noticed any difference in his mood. Mr Lovett said that the previous weeks had been particularly difficult, with difficulty contacting his wife, being unable to see his children, and the infection in his foot and new problems with his eyes, which could require a further

operation. Mr Lovett said that he had poor appetite but that this had improved recently as his meals were being brought to him, due to his poor mobility.

71. During the consultation, Mr Lovett said that he felt hopeless and had thoughts of suicide but denied any active plans to end his life. Mr Lovett spoke of the positives in his life, such as his family, and the psychiatrist recorded that these were protective factors.

72. The psychiatrist did not feel that Mr Lovett presented as being depressed, and agreed with the diagnosis of adjustment disorder, for which there are no medical treatments, but other options such as talking therapy and counselling were discussed. The decision was taken to stop Mr Lovett's prescription of sertraline as he had already stop taking it without any side effects, and he was encouraged to use the Listeners (prisoners trained by the Samaritans to offer support to peers) and the Samaritans, if he required. It was recorded that he would be reviewed again in 3 months, but the nursing team would follow up with him in 6 weeks.

73. There are no notes in Mr Lovett's medical record to indicate that his comments about not taking his antidepressant medication or his comments regarding his mood were shared, and there was no review of whether he should continue to keep insulin in his cell.

74. On 11 October, the Internal Risk Management Team (IRMT) reviewed Mr Lovett's application for contact with his children. The review concluded that Mr Lovett would be placed on Level 3 child contact. This meant that he would be able to have telephone contact with his children and receive visits. Mr Lovett was also placed on routine phone monitoring to ensure that any calls being made to his children were appropriate (meaning that officers would listen to his calls within 24 hours of them being made). After the meeting, the IRMT submitted the documentation to Mr Tim Hogg, Head of Public Protection at The Verne to action.

75. The keyworker spoke to Mr Lovett briefly on 12 October. Mr Lovett raised no issues or concerns, and he said that he was fine and that if anything happened before he saw him next, he would speak to the wing staff.

Events of 27 October and 28 October

76. At around 7.00pm on 27 October, a SO was helping to complete the routine checks. When he reached Mr Lovett's door, Mr Lovett was not standing at the cell door to be counted as he should have been. The SO opened the door and went into the cell. Mr Lovett was sitting in his chair. The SO asked Mr Lovett why he was not stood at the door. Mr Lovett started to cry and said that he had not spoken to his children that day and could not cope unless he spoke to them. The SO reassured Mr Lovett and told him to speak to staff in the morning and they would help him apply for emergency phone credit, and in the meantime, they could facilitate a call from the wing office. Mr Lovett calmed down.

77. The SO said that he reminded Mr Lovett that he could contact the Samaritans and also ask for a Listener if he needed to. He also said that if he felt upset during the night, he could speak with the night staff. The SO return to the wing office and completed a 24-hour monitoring form so that that staff could check on Mr Lovett

during the night. He had no concerns about Mr Lovett's risk to himself and did not think that starting ACCT monitoring was necessary.

78. At 7.50pm, Officer A arrived for the night duty. The day staff told her that a 24-hour monitoring form had just been started for Mr Lovett. Officer B also arrived for the night duty. Officer A updated him about Mr Lovett and said that the day staff had given little information as to the reasons, because the form had been completed just before they had finished their shift. Officer B said that when he looked at the form, it became clear that it was not the correct form and there was no information on the proposed frequency of observations or the reasons why additional monitoring was considered necessary.

79. Telephone calls made by prisoners are recorded, although unless they are subject to specific monitoring the calls will not be routinely listened to. The investigator was given access to Mr Lovett's call recordings following his death. At 8.15pm on 27 October, Mr Lovett called his wife and children. Mr Lovett sounded upset. He told his wife that he had been sitting for the past three hours with his insulin pen in his hand and that he could not do it anymore and just needed to hear his children's voices one more time. Mr Lovett then spoke to his children, and he sounded calm and upbeat. Mr Lovett told his wife that he would be gone soon and that the pain would stop. His wife continually told him not to be silly and reassured him. He then spoke to his children again before the call ended at approximately 8.34pm.

80. A SO was on night duty. He said that the previous SO had given him a brief handover about Mr Lovett over the telephone. He went to B1 wing as part of his normal rounds, and he spoke to Officer A. She told him that she had received little information in the handover from day staff and there was little information on the 24-hour monitoring form. He decided to go and speak to Mr Lovett himself. Officers A and B and the SO went to Mr Lovett's cell, and the SO and Officer B went in while Officer A remained outside. Mr Lovett was sitting in his chair and looked upset. The SO introduced himself and asked Mr Lovett if he could have a chat with him and he agreed. Mr Lovett was concerned about there being an error on his canteen application which resulted in him getting the incorrect phone credit, although he confirmed that he had just spoken to his family and that he had enough credit for another call later.

81. The SO asked Mr Lovett if he had any thoughts of self-harm. Mr Lovett said that he did not. The SO offered him support from a Listener and Mr Lovett declined. The SO told Mr Lovett that if he felt he needed to talk to staff he could press the cell bell, and that as a precaution, staff would make some checks on him through the night. It was agreed that staff would complete one check before midnight and two after midnight. (Prison staff conducted welfare checks on Mr Lovett during the night as planned and they did not report any issues or concerns.)

82. At 9.15pm, Mr Lovett phoned his wife again. During the call Mr Lovett told her that he had assured the SO that he would not harm himself but said that the 'pen' had been loaded since 3.30pm that afternoon. Mr Lovett's wife told him to unload it. Mr Lovett then spoke to his children before speaking to his wife again. They talked about the support he had received from an officer, and he asked his wife to email the officer about arranging a visit with the children. The call finished at 9.34pm, and Mrs Lovett sent the email to Mr Hogg at 9.53pm (the email did not contain any details of Mr Lovett's thoughts of suicide). (Mr Hogg read the email when he

returned to work on 29 October and also noted that the paperwork relating to monitoring Mr Lovett's calls had not been actioned.)

83. At 7.30am on 28 October, Officer C arrived on B1 wing for duty. Prison staff told him about Mr Lovett's 24-hour monitoring form. Mr Lovett went to the wing office and asked the officer about his missing telephone credit. The officer recorded their interaction on the monitoring form. He told Mr Lovett that he would try and rectify the problem. Mr Lovett completed the relevant applications and appeared to be all right. The officer said that he had no concerns about his contact with Mr Lovett. Staff recorded no other concerns or significant contact with Mr Lovett during the day.

84. At 7.00pm, Officer C and a colleague completed a routine check. Mr Lovett was not standing at his cell door as he should have been. The officer looked into the cell and Mr Lovett was asleep and snoring. The officer said that he noted him moving. Staff did not raise any concerns about Mr Lovett during the night, he did not use his emergency cell bell, and as his 24-hour monitoring form had been closed so he was not subject to any additional welfare checks.

Events of 29 October

85. At approximately 7.30am on Saturday 29 October, three officers carried out the early morning routine check. When Officer B looked into Mr Lovett's cell, he said that Mr Lovett was lying on his back and appeared to be asleep, he did not see anything suspicious and was satisfied that he had accounted for Mr Lovett and continued with the routine check.

86. At approximately 8.50am, Officer D went to get those prisoners who needed to collect their morning medication, he also went to remind Mr Lovett that he had a video call with his wife at 9.00am. He went into Mr Lovett's cell, and he could tell immediately that something was wrong. From Mr Lovett's presentation, he believed that Mr Lovett was dead. He radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). Control room staff called an emergency ambulance.

87. Two officers responded. Officer E said that Mr Lovett was lying on his back and there was foam around his mouth. She saw an insulin pen lying next to Mr Lovett on the bed and the cap was off. The staff said that Mr Lovett was cold to the touch and there were no signs of life and clear signs of rigor mortis. They decided that cardiopulmonary resuscitation (CPR) would not be appropriate given Mr Lovett's presentation. Nursing staff arrived at the cell at 9.04am, and after observing Mr Lovett, they agreed that resuscitation would be inappropriate and futile. A senior staff nurse confirmed that Mr Lovett had died.

88. While in the cell, Officer C and Officer E saw a note propped up on the chair next to Mr Lovett's bed. They said that they did not touch the note but were able to read some of what was written on it. The note indicated that Mr Lovett had intended to take his own life. The police later took the note as evidence.

Information received after Mr Lovett's death

89. After Mr Lovett's death, the police provided us with additional information following their investigation. During the cell search, the police found a total of eight insulin pens: five rapid acting insulin pens and three long-acting insulin pens. Each pen contained 100 IU. The insulin pens were scattered around the cell, two were in the safe and two were in the sharps bin. All of the pens were empty.

90. The police told us that insulin levels retrieved from Mr Lovett's Freestyle Libre glucose monitoring system showed that on Friday 28 October, Mr Lovett's blood glucose level was consistently below 4.0mmol/l all day, apart from one reading at 4.1mmol/l. A reading below four is classed as hypoglycaemic (low blood sugar) and as such, Mr Lovett's alarm should have gone off and he should have taken action to correct his blood glucose. There is no evidence that he notified nursing staff or officers to any issues.

Contact with Mr Lovett's family

91. The prison appointed a prison family liaison officer (FLO). When Mr Lovett was found dead, his wife was waiting to speak to him on the video call. Prison staff told her that the video call was unable to take place as arranged. They did not inform her that Mr Lovett had died at that time.

92. At 1.30pm on 29 October, the FLO and the Governor visited Mr Lovett's wife at her home address and broke the news of Mr Lovett's death. The FLO remained in contact with Mr Lovett's wife and arranged for the family to visit the prison.

93. The prison contributed to Mr Lovett's funeral costs in line with the national policy.

Support for prisoners and staff

94. After Mr Lovett's death, the staff involved in the emergency response attended a de-brief to ensure they had the opportunity to discuss any issues arising. The prison care team, PAM Assist, and TRiM practitioners offered them support.

95. The prison posted notices informing other prisoners of Mr Lovett'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 Mr Lovett's death.

Post-mortem report

96. The Coroner gave Mr Lovett's cause of death as insulin overdose. Hypertensive and ischaemic heart disease were listed as contributory factors.

97. The post-mortem did not provide information about how much insulin Mr Lovett had taken, but the investigator was told that the contents of one insulin pen could be sufficient to cause a fatal overdose.

Findings

98. Mr Lovett died by intentional overdose of his prescribed insulin, which he was allowed to keep in his possession. Our investigation has considered the decision to allow him to keep his insulin in his cell, and the subsequent management of that process, and whether prison staff should have had any concerns about his risk of suicide in the days before his death.

Assessment of Mr Lovett's risk

99. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Lovett had risk factors for suicide. It was his first time in prison, he considered that he had been unfairly convicted and had his appeal against his conviction refused. He had ongoing chronic physical health problems, had suffered with mental health issues and been sectioned under the Mental Health Act in the past. Mr Lovett had also attempted suicide several times, most recently by taking an overdose of his prescribed insulin prior to his conviction. He was placed on ACCT monitoring on his arrival at Winchester due to these factors and this was appropriately managed. The document was only closed after staff assessed that his risk had sufficiently reduced.

100. While at The Verne, staff had some concerns about Mr Lovett's welfare. His behaviour was not always acceptable, and he was subject to basic regime more than once. His wife called the prison several times to raise concerns about her husband's well-being, and he was subject to periods of increased welfare checks (including the day before he died). In September, Mr Lovett told his psychiatrist that he had thoughts of suicide, but prison staff were not aware, and the psychiatrist did not consider that ACCT monitoring was necessary at that time.

101. When asked by prison staff, Mr Lovett always maintained that he was fine, had no concerns and had no thoughts of suicide or self-harm. Contact with his family was clearly important to him, and he had recently been allowed telephone contact with his children. In his conversations with his wife in the days leading to his death, Mr Lovett clearly expressed his thoughts of suicide and his intended method, but staff were not monitoring the calls (which we discuss in a subsequent section) and so they were not aware.

102. While there were signs that Mr Lovett was upset at times between 27 and 29 October, we do not think that staff had particular reason to consider him at high risk of suicide or to begin ACCT monitoring.

Clinical care

103. The clinical reviewer concluded that the clinical care Mr Lovett received at The Verne was of a reasonable standard and equivalent to what he could have expected to receive in the community. There were, however, some areas of care that were not equivalent, particularly in relation to the management of his diabetes.

The decision to allow in possession insulin

104. Mr Lovett's diabetes management was complex, due to his reluctance to accept professional advice to improve his condition. He admitted that he did not eat regular meals (an important part of diabetes management) and this meant that he needed insulin outside the hours that healthcare were on duty at The Verne. Healthcare staff had to balance the risk of serious consequences of poorly managed diabetes on his health against his past history of overdosing on insulin. The clinical reviewer is satisfied that the multi-disciplinary decision to allow Mr Lovett to keep two insulin pens in his cell was reasonable and he was regularly discussed at the multi-disciplinary team meetings. However, we found little documented evidence to understand how the risk assessment was carried out, or what checks and safeguards were put in place to mitigate the risk of overdose. The Head of Healthcare acknowledged that record keeping was not of the standard it should have been.

105. When Mr Lovett died, the police found eight used insulin pens – some short action and some longer action - in his cell, amounting to just over a month's supply. He was supposed to keep no more than two pens in his cell at any one time and was supposed to exchange empty pens for a new one at the medication hatch as and when needed. The Head of Healthcare said that Mr Lovett could be very challenging and did not always bring his empty pens back. There is no evidence that his failure to abide by the conditions of keeping insulin in his cell lead to a review of his risk. She confirmed that there is now an alert on prisoners' medical records to prompt the return of empty pens or for nurses to enter a reason why this has not happened.

106. Mr Lovett also had an excessive number of boxes of Nurofen (ibuprofen) in his cupboard. Prisoners can purchase pain relief medication through the prison shop, but Mr Lovett was also prescribed it and collected it from the medication hatch. The clinical reviewer questioned the robustness of the healthcare teams in possession policy and compliance checks.

107. The clinical reviewer concluded that the care Mr Lovett received for his diabetes was not equivalent to what he could have expected to receive in the community. As well as the issues noted above, she noted omissions in care plans and reviews, and failures to record his blood glucose readings at significant points. However, the clinical reviewer acknowledged that management of type 1 diabetes is particularly difficult in prison. We make the following recommendation:

The Head of Healthcare should ensure that:

- **blood glucose levels are taken at reception for all diabetics and those with a Freestyle Libre sensor and ensure the readings are recorded in the prisoner's medical record at reception,**
- **there is a system in place to monitor use of glucose tablets and overuse should prompt a diabetic medication review; and**
- **there is an in-possession policy in place, to identify whether a prisoner is able to have weekly or monthly prescriptions in possession which includes vigorous risk assessment, compliance**

monitoring with the medication regime and random cell checks to count medications.

108. The clinical reviewer identified some areas of good practice. She found that a particular nurse's record keeping was excellent; a full NEWS 2 assessment had been well documented and there was evidence of prompt and appropriate follow up and escalation. The clinical reviewer also found that there were examples of excellent multidisciplinary team working, including a good process for referral to and attendance at these meetings.

24-Hour monitoring form

109. The 24-hour monitoring form was introduced at The Verne at the request of the area manager to allow for documented, short-term observations to be made on prisoners who were felt to need some additional monitoring. The investigator was told that it was not intended to replace the ACCT process and should not have been used instead of an ACCT. We are satisfied that while Mr Lovett was twice subject to 24-hour monitoring, there were no clear indications that he should have been subject to ACCT monitoring instead. However, it was clear from interviews with staff that there was some confusion about when the form should be used and for what purpose.

110. The investigator discussed this with the Governor. Given the Governor's own concerns about the potential for confusion between the 24-hour monitoring process and ACCT, he withdrew the 24-hour monitoring form with immediate effect on 6 November.

Governor to note

Phone Monitoring

111. Mr Lovett was subject to Level 3 child protection measures and as a result, his telephone calls with his family should have been monitored. Although the documentation for phone monitoring had been completed, it had not been actioned several weeks later.

112. In the week prior to 29 October, Mr Lovett telephoned his family 13 times and indicated that he was having thoughts of suicide. Had Mr Lovett's calls been monitored, staff might have identified his risk and taken action to provide additional support. The Governor will wish to consider this.

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