Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Lovatt, a prisoner at HMP Dovegate, on 22 December 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Kevin Lovatt died on 22 December 2017 at HMP Dovegate as a result of an obstruction in his throat. Mr Lovatt was 41 years old. I offer my condolences to Mr Lovatt's family and friends.

Mr Lovatt had a history of illicit drug use and mental health issues. He was suspected of using psychoactive substances and non-prescribed medication at Dovegate.

On the day of his death, staff suspected that Mr Lovatt had been passed an illicit item during a visit and was concealing the item in his underwear or on his body. When Mr Lovatt refused to allow staff to search him, staff attempted to restrain him. At some point during the restraint, Mr Lovatt swallowed the item and began choking. Despite their best efforts, prison and healthcare staff could not remove the package from Mr Lovatt's throat and he died.

I am concerned that prison staff did not call an emergency medical code when Mr Lovatt began choking. Although this did not affect the outcome for Mr Lovatt, such delays could make the difference between life and death in other cases.

I am also concerned about the availability of drugs at Dovegate. The prison will need to reassess their substance misuse policy in line with the Prison Service's Prison Drugs Strategy.

Finally, I am concerned that this is not the first case we have investigated in which a prisoner has choked to death after swallowing an illicit item during a restraint. A recommendation we made on this subject in 2014 was accepted but not implemented. I have, therefore, recommended once again that the Director General of the Prison Service provides staff with clear guidance on what to do if a resistant prisoner has something in his mouth.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2020**

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Summary

Events

1. Mr Kevin Lovatt was recalled to prison in March 2017 after breaching the conditions of his licence. He was transferred to HMP Dovegate in April. In September, he was sentenced to a further four months in prison.

2. Mr Lovatt had a history of substance misuse and mental ill health. He was suspected of using illicitly obtained prescription medication and was found under the influence of psychoactive substances.

3. On 22 December, during a visit from his family, prison custody officers (PCOs) suspected that Mr Lovatt had been passed an illicit item and concealed it in his underwear. Mr Lovatt refused to cooperate with a full search and became aggressive.

4. The PCOs started control and restraint procedures and then radioed for healthcare assistance because Mr Lovatt was choking. They could see he had something stuck in his throat.

5. Paramedics arrived at 2.56pm and removed the item from Mr Lovatt's throat and started advanced life support procedures. Mr Lovatt continued to deteriorate and at 3.27pm, it was confirmed that Mr Lovatt had died.

Findings

6. Mr Lovatt had a history of mental health and substance misuse issues. We are concerned that the mental health team missed his initial referral and he was not seen until shortly before his death.

7. Dovegate has a substance misuse policy, with distinct processes for managing prisoners who fail a mandatory drugs test and are suspected of using PS. The substance misuse team did not comply with the procedures for managing a prisoner with a substance misuse history.

8. We are satisfied that it was not unreasonable for staff to use force on Mr Lovatt when they suspected that he had been passed an illicit item during his visit.

9. However, we are concerned that this is not the first case we have investigated in which a prisoner has choked to death after swallowing an item during a restraint. We made a previous recommendation about this following a death in 2014. Although our recommendation in that case was accepted, we are concerned that it has not been implemented. It remains our view that staff need clear guidance on what to do when a resistant prisoner swallows an item.

10. Prison staff did not use a medical emergency code when Mr Lovatt began choking. Although this did not cause a delay in paramedics attending, it could be crucial in other emergencies.

Recommendations

- The Head of Healthcare and the manager of the mental health team should ensure that:
    - prisoners with mental health issues are seen promptly by the mental health team; and
    - prisoners receive appropriate reviews which are recorded and implemented.
- The Director and Head of Healthcare should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drugs strategy.
- The Director should ensure that body-worn video cameras are worn in key areas of the prison such as visits.
- The Director should ensure that all staff are aware of and use the appropriate emergency code when they discover an apparent medical emergency.
- The Director should ensure that the key drug issues at Dovegate are identified and that the prison's local drugs strategy is reviewed regularly to ensure that these key issues are being addressed.
- The Director General of the Prison Service should ensure that there is clear guidance and training on the safe use of force when resistant prisoners have items in their mouths which might compromise their breathing.

The Investigation Process

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

12. One of the investigator's colleagues visited Dovegate on 12 January 2018. He obtained copies of relevant extracts from Mr Lovatt's prison and medical records.

13. NHS England commissioned an independent clinical reviewer to review Mr Lovatt's clinical care at the prison. The investigator and the clinical reviewer interviewed 10 members of staff at Dovegate on 4 and 5 April 2019. The investigator interviewed one member of staff on 10 June.

14. Our investigation was suspended while we waited for the cause of death and the conclusion of the police investigation. This delayed the disclosure of the initial report.

15. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. We contacted the solicitor acting on behalf of Mr Lovatt's family, to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Lovatt's mother wanted to know why it had taken so long to tell her that her son had died and why the news of his death was broken by a police officer.

17. We have answered Mr Lovatt's mother's questions in this report.

18. Mr Lovatt's family received a copy of the initial report. They did not make any comments.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Dovegate

20. HMP Dovegate is a Category B prison in Staffordshire run by Serco. The main prison holds around 933 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men. Care UK provides 24-hour healthcare services, seven days a week. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

21. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Dovegate in June 2017. Inspectors found the prison was having to contend with a number of physical and operational security challenges which included confronting organised criminality, mobile phones and drugs. Improvements to the management of intelligence were evident and interventions were beginning to be effective. However, drug testing and contraband finds indicated that the availability of illicit substances, including brewed alcohol and psychoactive substances, was considerable and the prison needed to have a better coordinated response to reducing drug supply. Inspectors found that that substance misuse interventions to help reduce demand were, in contrast, excellent.

Independent Monitoring Board

22. 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 last annual report, published in February 2018, the IMB was very concerned about the availability and use of psychoactive substances, which caused additional pressures for both healthcare staff and prison staff.

Previous deaths at HMP Dovegate

23. Mr Lovatt's was the third death at Dovegate since December 2015. One of the previous deaths was self-inflicted and the other was due to natural causes. There have been three self-inflicted deaths, two drug-related deaths and three deaths from natural causes since.

24. In February 2019, we made a recommendation about the use of emergency codes at Dovegate. The prison said they would remind all staff about the use of emergency codes in a Director's notice. The target date for completion was March 2019.

Psychoactive Substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health,

there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

28. On 17 March 2017, Mr Kevin Lovatt was recalled to prison after he breached the conditions of his licence and was sent to HMP Nottingham. On 24 April, he was transferred to HMP Dovegate. On 4 September, Mr Lovatt was sentenced to a further four months in prison for burglary and returned to Dovegate.

Previous history

29. Mr Lovatt had a history of substance misuse and mental health problems. He was prescribed methadone (for the management of opioid misuse), diazepam (an antidepressant), nitrazepam (for anxiety and insomnia) and pregabalin (to treat epilepsy, anxiety and nerve pain). Mr Lovatt was under the care of the mental health team at Nottingham.

30. Mr Lovatt tested positive for hepatitis C and was under the care of the prison's blood borne virus clinic.

HMP Dovegate

31. On 24 April, a healthcare manager completed Mr Lovatt's reception health screen when he arrived at Dovegate. She noted Mr Lovatt's prescribed medication and made a referral to the prison's substance misuse team and mental health team. A nurse from the mental health team added Mr Lovatt to the triage list on 25 April.

32. The same day, a substance misuse worker saw Mr Lovatt and reviewed his substance misuse care plan. She noted that Mr Lovatt was prescribed 35ml of methadone a day. She did not complete a Drug Intervention Programme referral (aimed at engaging Class A drug users in treatment) due to the length of Mr Lovatt's sentence. Mr Lovatt agreed to attend substance misuse support groups.

33. On 19 May, Mr Lovatt saw a nurse from the substance misuse team, and asked to reduce his methadone dose by 5ml because he wanted to be drug free when he left prison.

34. On 7 June, Mr Lovatt discussed his methadone dose again with a nurse. His dose was reduced by 5ml to 30ml. Mr Lovatt also wanted to discuss his mental health and antidepressant medication. There is no evidence that the nurse made a referral to the mental health team or a prison GP.

35. On 15 June, Mr Lovatt started anxiety and addiction work with a nurse to explore his anxiety and pattern of drug use.

36. On 3 July, the results of a mandatory drugs test (MDT) showed that Mr Lovatt had used psychoactive substances (PS). Prison staff submitted an intelligence report and made a referral to the substance misuse team. Mr Lovatt was reduced from standard to basic status on the prison's incentives and earned privileges scheme (IEP) for seven days. (The IEP scheme aims to encourage and reward responsible behaviour. There are three levels, basic, standard and enhanced.) There is no evidence that a member of the substance misuse team saw Mr Lovatt after his positive MDT.

37. On 4 and 14 July, Mr Lovatt was admitted to hospital with chest pain. The results of investigations were normal and hospital doctors prescribed a glyceryl trinitrate spray (GTN - used to relieve angina and chest pain) to alleviate his symptoms.

38. On 20 July, Mr Lovatt had an ECG with normal results. A prison GP completed a cardiovascular disease risk assessment and made a referral to a gastroenterologist for an oesophago gastro-duodenoscopy (an examination of the oesophagus, stomach and intestine).

39. Between 1 and 30 August, Mr Lovatt completed a methadone detoxification programme which reduced his dose to 25ml. This was followed by a 28-day subutex detoxification programme (subutex is an opioid used to treat opioid addiction and dependence). The GP prescribed zoplicone for five days to alleviate Mr Lovatt's symptoms of insomnia.

40. On 7 September, the results of a mandatory drugs test (MDT) showed that Mr Lovatt had used PS. Prison staff submitted an intelligence report and made a referral to the substance misuse team. Mr Lovatt was reduced from standard to basic status on the prison's incentives and earned privileges scheme for seven days. There is no evidence that a member of the substance misuse team saw Mr Lovatt after his positive MDT.

41. On 20 September, a nurse from the substance misuse team saw Mr Lovatt to discuss his detoxification. Mr Lovatt did not express any concerns.

42. On 3 October, a substance misuse worker saw Mr Lovatt and noted he had finished the subutex detoxification and was taking zopiclone (a sleeping tablet). Mr Lovatt said that he felt well and did not express any concerns.

43. During a review on 18 October, Mr Lovatt told a nurse that he was using illicit subutex. He refused to take methadone but agreed to start lofexidine (to relieve the symptoms of opioid withdrawal). On 20 October, Mr Lovatt told a substance misuse worker he wanted to be drug free when he left prison.

44. On 25 October, Mr Lovatt complained of chest pain. The results of an ECG were normal and a prison GP advised Mr Lovatt to use his GTN spray.

45. A nurse reviewed Mr Lovatt on 31 October when the course of lofexidine ended. Mr Lovatt said he felt unwell, had swollen hands, a lump in his testicle, pains in his chest when breathing in and spots under the skin on his back. A prison GP prescribed a further course of zopliclone. Mr Lovatt remained on the substance misuse team caseload but was discharged from the clinical caseload.

46. On 10 November, a substance misuse worker saw Mr Lovatt who said that he was concerned about his health. He told her he was taking 5mg a day of illicit subutex. She advised Mr Lovatt to reduce his intake of illicit subutex and amended his substance misuse care plan to reflect this.

47. On 14 November, prison officers referred Mr Lovatt to the substance misuse team after they found suspected PS in his cell.

48. On 16 November, a nurse referred Mr Lovatt to the mental health team because he felt anxious. On 17 November, a nurse from the mental health team noted

that Mr Lovatt had been initially referred during his reception health screen and said that she would complete an incident form to record the missed referral. There is no evidence that an incident form was completed. The nurse made Mr Lovatt an appointment for 23 November. Mr Lovatt did not attend this appointment due to an incident in the prison.

49. A substance misuse worker reviewed Mr Lovatt on 4 December. Mr Lovatt said he wanted to stop using subutex but was not in the right frame of mind.

50. On 6 December, a nurse completed a mental health assessment. Mr Lovatt said that he was taking illicit subutex and needed the support of the substance misuse team. He reported poor sleep and anxiety. The nurse arranged an appointment for 20 December which Mr Lovatt did not attend because of another incident in the prison. The nurse created a mental health care plan on 22 December which said that Mr Lovatt would start one-to one work to manage his symptoms of anxiety. An appointment was arranged for 3 January 2018.

51. On 11 December, prisoners reported that Mr Lovatt had taken PS. Prison staff submitted a security intelligence report and made a referral to the substance misuse team.

52. On 18 December, a prison GP saw Mr Lovatt who complained of chest pain. Mr Lovatt said he felt anxious and asked the GP for methadone. Mr Lovatt's urine tested positive for subutex. The GP prescribed 15ml of methadone and made a referral to the substance misuse team.

53. On 21 December, a nurse assessed Mr Lovatt using the Clinical Opiate Withdrawal Scale (COWS, which assesses the severity of opiate withdrawal). The nurse noted that Mr Lovatt was sweating, and his facial expressions indicated that he was in pain. Because Mr Lovatt had only taken two doses of methadone, the nurse could not assess his level of toxicity. The nurse made an appointment with a GP to assess Mr Lovatt the next day. Mr Lovatt did not attend because he had a visit from his family.

Events of 22 December 2017

54. Prisoners' telephone calls on prison phones are recorded and a sample of them are listened to by prison staff. Mr Lovatt made a number of calls on 22 December and the investigator listened to them.

55. At 10.50am, Mr Lovatt telephoned his son and told him to make sure he visited that day. Mr Lovatt sounded cheerful and upbeat. At 10.55am, Mr Lovatt called his mother and had a general conversation about visiting the prison.

56. At 12.33pm, Mr Lovatt telephoned his friend and asked if he was on his way to visit him. Mr Lovatt spoke about 'carb' and said, "You know what I mean yeah?" Mr Lovatt sounded evasive. Mr Lovatt called his friend again at 12.53pm. He had a brief conversation about his mother then spoke about 'carb' again. Mr Lovatt's friend confirmed that he understood what Mr Lovatt meant.

57. At approximately 2.35pm, a prison custody officer (PCO) was on duty in the visits area. Mr Lovatt was seated at table 15 with four visitors (his mother, his son, a friend and a small child). The PCO told the investigator that Mr Lovatt was acting

suspiciously so she used the security cameras to observe Mr Lovatt more closely. The PCO said that she believed Mr Lovatt had hidden an item in his underwear. She approached Mr Lovatt and ended the visit.

58. CCTV footage shows that the PCO who had ended the visit along with two male PCOs escorted Mr Lovatt from the visits hall to the search area at about 2.51pm. (There is no CCTV in the search area.) In their statements, the two male PCOs said that they told Mr Lovatt he would have a full search because he was suspected of concealing an item, which Mr Lovatt denied.

59. The two male PCOs started to search Mr Lovatt in the search area (a small cubicle with a curtain for privacy). The female PCO remained outside for reasons of decency. One of the male PCOs said that Mr Lovatt became agitated and argumentative and refused to show his hands. Mr Lovatt used his right hand to reach inside his trousers. The other male PCO tried to take hold of Mr Lovatt's right arm to ensure he did not retrieve the concealed item.

60. One of the male PCOs said that Mr Lovatt became aggressive and started to fight against him and the other male PCO. He heard the other male PCO say, "He has put it in his mouth." The female PCO said she heard a scuffle and then Mr Lovatt and the two officers "came flying through the curtain" and all fell on the floor beside her, with Mr Lovatt face down. Mr Lovatt fell forward onto his chest outside of the search area and the three PCOs started control and restraint procedures. The female PCO tried unsuccessfully to hold Mr Lovatt's arm to prevent him moving it to his mouth.

61. The female PCO told the investigator that she pressed the emergency alarm on her radio for assistance. At approximately 2.50pm, a Custodial Operations Manager (COM) and a PCO arrived. Mr Lovatt was lying on his side with his feet inside the search area. Mr Lovatt was still fighting against prison staff.

62. The COM applied handcuffs behind Mr Lovatt's back and helped him onto his knees. Mr Lovatt seemed to be trying to swallow something but then began salivating. The female PCO then saw that Mr Lovatt had turned purple, was choking and had a visible lump in his throat. The Deputy Director arrived and could see that Mr Lovatt had something in his mouth and was panicking. The COM immediately removed the hand cuffs.

63. At approximately 2.53pm, a nurse received a message over the radio to attend the visits area. The control room did not provide any information about the incident. Two nurses immediately attended and found Mr Lovatt on his knees with his trousers down. Prison officers told them that Mr Lovatt had something stuck in his throat. One of the nurses said Mr Lovatt's face was blue, he had vomited and he was unresponsive. A PCO performed the 'Heimlich manoeuvre' (a procedure to dislodge an obstruction from a person's windpipe in which a sudden strong pressure is applied on their abdomen between the navel and the ribcage) without success. The female PCO put her hand in Mr Lovatt's throat to try to reach the item. She said she could feel it with her finger nail but could not reach it.

64. One of the nurses asked prison officers to radio a code blue medical emergency, which indicates a prisoner is unable to breathe or having difficulty breathing.

Paramedics were at the prison dealing with a separate incident and arrived in the visits area at approximately 2.56pm. The paramedics used forceps to remove the object from Mr Lovatt's throat - it was a white balloon like object about one or two inches long - and started advanced life support. Mr Lovatt continued to deteriorate and at 3.27pm, he died.

65. Prison staff completed the use of force paperwork after Mr Lovatt's death and said that the incident was a spontaneous use of force. The reason given for force being used was to prevent Mr Lovatt from swallowing a package and because his behaviour was threatening and aggressive.

Contact with Mr Lovatt's family

66. After Mr Lovatt's death, the police asked prison staff to remove Mr Lovatt's family to a secure area of the prison where they remained in separate rooms. At approximately 6.30pm, the Deputy Director and a police officer informed Mr Lovatt's family members of his death.

67. Mr Lovatt's nominated next of kin was his mother. The prison appointed two family liaison officers (FLOs). At the request of the police, they did not contact Mr Lovatt's mother until 3 January 2018. The FLOs maintained contact with Mr Lovatt's mother and, in line with Prison Service instructions, the prison contributed to the costs of his funeral.

Support for prisoners and staff

68. After Mr Lovatt's death, the Head of Safer Custody held a debrief for staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

69. The prison posted notices informing other prisoners of Mr Lovatt'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 Lovatt's death.

Post-mortem report

70. The post-mortem examination found that Mr Lovatt had a pattern of bruising around his upper limbs consistent with relatively forceful gripping. There was limited bruising to his neck. The pathologist said that he could not exclude the possibility that this was the result of pressure being applied to the neck, but the profile did not suggest that. The alternative explanation was that this occurred during the attempts to remove the object.

71. The pathologist concluded that Mr Lovatt died from an obstruction of the internal airways with close temporal relationship (that is, close in time) to restraint. The pathologist commented that there was no evidence to support that restraining Mr Lovatt directly caused his death. He said, "To put it simply an episode whereby obstruction of the internal airways arises and the obstructing object cannot be self or third party removed will cause death."

72. Toxicology tests detected the presence of methadone in Mr Lovatt's blood at a level consistent with his prescribed medication.

Findings

Mental healthcare

73. Mr Lovatt had a history of mental health problems and had been prescribed medication for anxiety and depression in the past. The clinical reviewer found that the mental health team noted Mr Lovatt's referral when he arrived at Dovegate in April 2017 but did not add him to the waiting list to be seen. The mental health team did not complete a mental health assessment until 6 December 2017 and his care plan was not created until two weeks later.

74. The clinical reviewer was told that since Mr Lovatt's death, urgent referrals to the mental health team are seen within two days, and within five days for routine referrals. Staffing levels have increased and prisoners who do not attend appointments are contacted on the wing. While we note the changes to mental health team, it is important that prisoners with a history of mental health issues are appropriately assessed and have a documented care plan. We recommend that:

    The Head of Healthcare and the manager of the mental health team should ensure that prisoners with mental health issues are seen promptly by the mental health team. Prisoners should receive appropriate reviews which are recorded and implemented.

Clinical care

75. The clinical reviewer concluded that, overall, the care that Mr Lovatt received from healthcare staff at Dovegate was equivalent to that which he could have expected to receive in the community.

76. The clinical reviewer found that Mr Lovatt was regularly reviewed and monitored by healthcare staff. Nurses promptly attended the emergency incident and provided appropriate life support techniques.

77. The clinical reviewer has made a number of recommendations to the Head of Healthcare about prescribed medication, sharing information about prisoners who are under more than one healthcare team, and training staff in the use of forceps, that we do not repeat in this report but which the Head of Healthcare will need to address.

Substance Misuse

78. Mr Lovatt had a complex history of substance misuse and the substance misuse team saw him promptly when he arrived at Dovegate. The clinical reviewer found that Mr Lovatt completed appropriate detoxification programmes. While Mr Lovatt appeared motivated to detoxify, his two positive MDTs and suspected PS use indicated that he was not coping with the detoxification programme and needed support from the substance misuse team.

79. Despite a referral from prison staff after he failed an MDT, the substance misuse team did not see Mr Lovatt to investigate why he had continued to take illicit substances while he was on a detoxification programme. We recommend that:

The Governor and Head of Healthcare should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drugs strategy.

Use of Force

80. CCTV footage shows Mr Lovatt leaving the visits area with prison custody officers. None of the prison staff were wearing body-worn cameras which would have provided footage of the incident – although not of the full search when the restraint began as full searches should not be filmed.

81. The Deputy Director told the investigator that since Mr Lovatt's death, the prison has increased the availability of body-worn cameras. He said that, on average, thirty prison staff now wear a body-worn camera and the prison ensures these are available to staff in targeted areas such as visits. He said that the prison intends to increase the use of body-worn cameras in the prison. We recommend:

The Director should ensure that body-worn video cameras are worn in key areas of the prison such as visits.

82. Prison Service policy on the use of force is set out in Prison Service Order (PSO) 1600. Paragraph 2.2 states that the use of force is "justified, and therefore lawful, only:

- if it is reasonable in the circumstances
- if it is necessary
- if no more force than is necessary is used
- if it is proportionate to the seriousness of the circumstances."

83. PSO 1600 says that when staff need to decide whether or not force is necessary, they must take into account what harm they are trying to prevent. The PCOs involved in the control and restraint told the investigator that Mr Lovatt refused to comply with the full search. He became argumentative and started to fight with the searching officers and they believed he was trying to conceal an illicit package. We therefore consider that Mr Lovatt's behaviour could reasonably have been considered by staff to pose a risk to them and to the good order of the prison. We are therefore satisfied that the use of force was appropriate.

84. However, we investigated the death of a prisoner at another prison in October 2014 who also choked to death after swallowing a package of drugs and being restrained. Following that investigation, we recommended that the Chief Executive of what was then the National Offender Management Service (NOMS) should ensure that there was clear guidance and training on the safe use of force when resistant prisoners have items in their mouths which might compromise their breathing.

85. NOMS said in response that they accepted that the use of force guidance needed to be revised to include more specific guidance for staff on the action to be taken when a resistant prisoner has items concealed in their mouth. They said that they were in the process of producing a staff training DVD on the safe use of

force and would consider the best way to include specific guidance on this point in the DVD. They said this would be completed by December 2015.

86. We obtained a transcript of the DVD, dated 2016, which Dovegate confirmed they use in local staff training. Although this emphasises the importance of ensuring that a prisoner's airway is not obstructed during a restraint, it does not provide specific advice on what staff should do if they know or suspect that a resistant prisoner has concealed an item in his mouth or attempted to swallow an item. We are, therefore, concerned that, although our previous recommendation was accepted, it has not been implemented.

87. Staff regularly face a situation if which resistant prisoners place an item in their mouth. Although we recognise that it is not possible to create a totally safe system of restraint, we consider that there remains a need for clear guidance on what to do in this specific situation.

88. We, therefore, recommend:

The Director General of the Prison Service should ensure that there is clear guidance and training on the safe use of force when resistant prisoners have items in their mouths which might compromise their breathing.

Emergency response

89. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It says that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team, or a manager to attend the scene before calling an ambulance. In line with the PSI, Dovegate has a local protocol, NTS 005/2017 issued on 8 March 2017.

90. When Mr Lovatt began to choke, none of the staff present used an emergency code as instructed in the PSI and local instructions. Use of the relevant code informs staff of the nature of the medical emergency, ensuring that healthcare staff respond with the appropriate medical equipment. In this case, when healthcare staff attended the incident, they did not know what medical equipment to take with them. The lack of an emergency code also meant that there was a delay in calling an ambulance.

91. As paramedics were already at the prison they responded quickly. However, in other circumstances the lack of an emergency code could have resulted in an unacceptable delay in paramedics attending. While we are satisfied that on this occasion, the failure to use an appropriate emergency code did not affect the outcome for Mr Lovatt, any delay in calling an ambulance when there is a medical emergency could be crucial in other emergencies. We recommend that:

The Director should ensure that all staff are aware of and use the appropriate emergency response code when they discover an apparent medical emergency.

Treatment of Mr Lovatt's family

92. After Mr Lovatt's death, the police asked prison staff to take his family to the legal visits area, where they remained in separate rooms. They were informed of his death about three hours after he died. Mr Lovatt's mother, his nominated next of kin, has asked why prison staff did not inform her of Mr Lovatt's death immediately and why the news was broken to her by the police.

93. PSI 15/2011, *Management of security at visits*, says that that, if visitors are found to have passed any illicit items to a prisoner, the police should be notified and the visitors prosecuted. In addition, PSI 64/2011, *Safer Custody*, says that following a death in custody, the prison must inform the police who will treat all deaths in custody as suspicious. The police investigation will have primacy over other investigations.

94. Mr Lovatt died after swallowing an item which appeared to have been passed to him in the visit. The police were informed and began an investigation into a possible or actual crime. In the circumstances we are satisfied that it was appropriate for the prison to follow the police instructions on the detention of Mr Lovatt's visitors.

95. PSI 64/2011 also says that, wherever possible, a prison family liaison officer (FLO) and another member of staff must break the news of a prisoner's death to his next of kin and that this must be done in person as soon as possible to avid the next of kin hearing of the death from another source. In this case, Mr Lovatt's family were isolated and there was no risk of them hearing of Mr Lovatt's death from anyone else. The police were investigating the possibility that they had committed offences leading to Mr Lovatt's death and they were, therefore, potential suspects.

96. We are satisfied that it was appropriate for the prison to accept that the police had the primary role in relation to Mr Lovatt's death at that time and to follow police instructions about when Mr Lovatt's family should be informed of his death. We are also satisfied that the prison acted appropriately in that a senior member of prison staff accompanied a police officer to inform Mr Lovatt's family.

97. Mr Lovatt's visitors were subsequently arrested by the police on suspicion of manslaughter and supplying a control drug. We note that it was later decided that there was insufficient evidence to charge Mr Lovatt's family with these offences.

98. We make no recommendation.

Reducing the supply of illicit substances

99. We are concerned that Mr Lovatt was able to obtain PS and illicit prescription-only medication while in Dovegate, and that he was able to obtain an illicit package during a visit (although we cannot say what it contained or how he obtained it). We note that both HM Inspectorate of Prisons and the Independent

Monitoring Board have expressed concern about the ready availability of drugs at Dovegate.

100. Drug trafficking, drug taking and trading are serious problems across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problems by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works. We welcome the fact that such guidance was issued in April 2019, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

101. In relation to reducing the supply of drugs, the new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

102. We, therefore, recommend:

The Governor should ensure that the key drug issues at Dovegate are identified and that the prison's local drugs strategy is reviewed regularly to ensure that these key issues are being addressed.

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