

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Sean Jarvis a prisoner at HMP Dovegate on 9 November 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*

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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 Sean Jarvis died on 9 November 2017, having been found hanged in his cell at HMP Dovegate. He was 28 years old. I offer my condolences to Mr Jarvis' family and friends.

Mr Jarvis had been released from prison on licence but was recalled in May 2017 and received a lengthy further sentence. He seemed to cope with this well and gave staff no cause for concern when he was transferred to Dovegate a couple of months later.

It appears, however, that Mr Jarvis was concerned about his relationship with his partner and that he was also struggling with depression. Wing staff were not aware of this and, therefore, had no reason to consider that he might pose a risk to himself.

I am very concerned that although Mr Jarvis made five requests to the mental health team for help with his mental health issues, he was not seen in person by anyone from healthcare. Healthcare staff relied instead on electronic communication at the expense of personal contact, and the opportunity to assess Mr Jarvis' mental state was, therefore, missed. I, therefore, share the clinical reviewer's view that the mental healthcare Mr Jarvis received at Dovegate was not equivalent to that which he could have expected to receive in the community.

I am also concerned that there is no evidence of any meaningful engagement with Mr Jarvis by wing staff during the four weeks he was at Dovegate.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**February 2019**

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# Summary

## Events

1. Mr Jarvis had been released from prison on licence but was recalled in May 2017, charged with a further offence. He had a history of depression and several previous incidences of self-harm, some serious. He was very low in mood on arrival in prison, and staff began to monitor him under Prison Service procedures for those at risk of self-harm. He settled after a few days and special monitoring was ended.
2. In July he was given a lengthy further sentence. He was assessed on his return from court but appeared to have accepted his sentence and was not judged to present a risk to himself. A few weeks later he asked to see the mental health team, reporting anxiety and depression. He was prescribed medication and referred for therapy.
3. On 11 October, Mr Jarvis was moved to Dovegate. On arrival, he appeared to be upbeat, and reported no concerns. Because of his history of anxiety and depression he was referred to the mental health team for assessment. A doctor confirmed his medication prescriptions and he was put on the waiting list for a group therapy course.
4. Between 12 October and 7 November, Mr Jarvis asked five times via Dovegate's electronic application system to see someone from healthcare to discuss his anti-depressant medication and mental health concerns. He said he was 'struggling' and becoming more anxious and depressed. He received electronic replies and was told that if he had any immediate concerns, he should see one of the nurses based on the wing. He did not do so.
5. He was given a place on the group therapy course but did not attend. Healthcare staff noted that he was not collecting his anti-depressant medication.
6. It appears that wing staff were not aware of Mr Jarvis' mental health concerns. There was nothing recorded in the wing book and only one entry in Mr Jarvis' electronic record documenting wing staff engagement with him.
7. On the morning of 9 November, Mr Jarvis made a number of telephone calls to his partner. They had been having problems in their relationship and the calls reflected this. (Again, wing staff were not aware of this.) His partner asked him to call her again in the afternoon.
8. Later that morning Mr Jarvis spoke to a prison officer about his application to move to the prison's therapeutic community. All prisoners were then locked in their cells. An officer noted Mr Jarvis sitting on the bed watching television. At approximately 10.45am, two prison officers went to conduct a routine check on Mr Jarvis' cell and found him hanging. They called an emergency over the radio and went into his cell. They cut him down and tried to revive him, soon joined by nurses. They continued trying to resuscitate Mr Jarvis until 11.30am, when ambulance paramedic staff pronounced him dead.

## Findings

### Mr Jarvis' healthcare

9. Mr Jarvis had no physical health issues but had a history of anxiety, depression and self-harm. He was appropriately referred to the mental health team at Dovegate, which put him on the waiting list for a course of group therapy.
10. In the next four weeks, Mr Jarvis contacted the healthcare team via the prison's electronic application system five times seeking help with mental health concerns which he said were getting worse. He received electronic responses telling him to speak to nurses on the wing or to see the doctor. He did not do so. He was not seen in person. Given his history of depression and self-harm, and the fact that healthcare staff were aware that he was not collecting his anti-depressant medication, it was not appropriate for healthcare staff to rely solely on electronic communication. He should have been seen in person.
11. There is no evidence that anyone from healthcare told wing staff that Mr Jarvis had reported that he was struggling with depression. As a result, wing staff were not aware that Mr Jarvis might be vulnerable.

### Assessment of risk

12. Mr Jarvis had been monitored briefly because of a risk of self-harm when he initially returned to prison but then gave no further cause for concern. During his time in Dovegate, prison staff had no reason to consider that he presented a risk to himself. It appears that he had been having difficulties in his relationship with his partner and that he felt he was struggling with depression, but this was not known to prison staff. We found little evidence of meaningful engagement with Mr Jarvis by wing staff during the four weeks he was at Dovegate.

### Emergency response

13. When staff raised the emergency alarm, the prison paramedic was in an area of the prison with a poor radio signal. There was therefore a short delay before she reached Mr Jarvis' cell.

## Recommendations

- The Head of Healthcare should ensure that when there appears to be an ongoing issue with a prisoner's medication, a member of staff should explore this with him in person.
- The Head of Healthcare should ensure that when a prisoner reports significant health concerns via the electronic application system, he should be seen in person.
- The Head of Healthcare should ensure that when a prisoner reports mental health concerns, healthcare staff should make wing staff aware.
- The Director and the Head of Healthcare should review radio coverage and ensure that there are adequate arrangements in place for staff who may be required in an emergency to be contacted without delay.

## The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator visited Dovegate in December 2017. He obtained copies of relevant extracts from Mr Jarvis' prison and medical records.
16. The investigator interviewed five members of staff from Dovegate and one prisoner, a friend of Mr Jarvis, from another prison.
17. NHS England commissioned a clinical reviewer to review Mr Jarvis' clinical care at the prison. He joined the investigator in interviewing staff.
18. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers, contacted Mr Jarvis' mother, to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. Mr Jarvis' mother asked about Mr Jarvis' medication, and whether prison staff were aware of Mr Jarvis' previous self-harm.
20. Mr Jarvis' mother received a copy of the initial report. She did not raise any further issues.

# Background Information

## HMP Dovegate

21. HMP Dovegate is 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, who took over from Serco Health in October 2014, provides healthcare services.

## HM Inspectorate of Prisons

22. The most recent inspection of HMP Dovegate was conducted in May and June 2017. Inspectors reported concerns over safety. Levels of self-harm were higher than in similar prisons although the prison was working to improve support for prisoners at risk of harming themselves and there was a good understanding of risk factors.

## Independent Monitoring Board

23. 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 30 September 2017, the IMB reported that healthcare services were improving but retention of staff was a problem.

## Automated application system

24. Dovegate has an automated messaging system for prisoners' use. There are terminals on the wings in the houseblocks which prisoners can use to make applications to any department in the prison, for example to make a medical appointment, order items from the canteen, or contact an offender supervisor. The system operates like email.

## Previous deaths at HMP Dovegate

25. Mr Jarvis was the first prisoner to take his own life in Dovegate since 2015. We have previously made recommendations around risk of self-harm for newly arrived prisoners.

## Key Events

26. In 2014, Mr Sean Jarvis was sentenced to six and a half years in prison. His medical file showed a history of depression, for which he had been prescribed medication. In HMP Wymott he saw a psychotherapist about his anxiety. His offender risk assessment noted a history of self-harm that included cutting and overdose, resulting in hospitalisation on some occasions. Mr Jarvis said that he had fallen into a coma after an overdose in February 2013.
27. Mr Jarvis was released on licence in January 2017 but was returned to prison in May, having been charged with causing grievous bodily harm.
28. On 22 May, Mr Jarvis arrived at HMP Preston. At his reception health screening Mr Jarvis said that he had recently seen a doctor because of depression and had been prescribed mirtazapine (an anti-depressant). He said that he had previously harmed himself, and showed scars on his arms. He said that he felt very low in mood and could not guarantee that he would not harm himself. Staff began to monitor him under Prison Service procedures to support those at risk of harming themselves (known as Assessment, Care in Custody and Teamwork, or ACCT). The following day, 23 May, Mr Jarvis had a secondary health screen. He was referred to the mental health team for assessment.
29. On 25 May, prison staff reviewed Mr Jarvis' ACCT status. The main issues of concern to him had been the possibility of receiving a long sentence, a lack of contact with his mother and his partner, and uncertainty about the status of his relationship with his partner. He said that he had no recent history of harming himself, the most recent time he had done so being four years previously over issues relating to access to his children. He said that he had never harmed himself in prison. He reported that he felt better than when he arrived in prison and had no intention of taking his own life. He had not had any anti-depressant medication since returning to prison, but had been referred to the mental health team for assessment, and arrangements were in hand to assess his medication. He said protective factors were the support of his mother and his partner, and they were making arrangements to visit him. The following day staff ended ACCT monitoring.
30. Mr Jarvis settled back into prison life. In early July he was assessed as suitable to hold his own medication in his cell. In late July he attended court and was given a sentence of 13 years and four months. He was assessed on return to prison and, while the sentence was longer than he had expected, he had no adverse reactions and staff found no reason to be concerned.
31. On 16 August, Mr Jarvis asked to see the mental health team. He was assessed on 2 September, when he reported feeling anxious, depressed and paranoid, although he said he had no thoughts of harming himself. He was referred for assessment for cognitive behavioural therapy (CBT, a talking therapy that helps people manage their problems by changing the way they think and behave). His medication was reviewed and he was prescribed mirtazapine and propranolol (to treat anxiety). He saw a psychotherapist on 20 September and agreed to engage in therapy.

32. On 11 October, Mr Jarvis was moved to Dovegate. The note of his reception interview showed that he was polite, co-operative and upbeat. Mr Jarvis said that he had no thoughts of harming himself, and had no concerns. He was given a reception health screening and again interacted well, giving no cause for concern. Because of his history of anxiety and depression he was, however, referred to the mental health team for assessment. His cell sharing risk assessment was marked as standard risk. In line with policy for new arrivals, staff checked on him once per hour during the night. The following day he had a first morning interview when he said that he had no history of self-harm and had not been monitored under ACCT procedures before. (This was not correct.) A prison doctor confirmed his prescriptions of mirtazapine and propranolol.
33. On 12 October, the mental health team examined Mr Jarvis' medical history. He had reportedly suffered from anxiety and depression for many years and had been diagnosed in 2010. In September he had seen a psychotherapist, and the mental health team in Preston had planned to offer him cognitive behavioural therapy to help him manage his anxiety and self-esteem. Mr Jarvis had expressed interest in joining the therapeutic community at HMP Wymott. The team saw no reason to consider him at risk of harming himself. He participated in prison life and had contact with his family. In Preston he had been assessed as trustworthy to hold his medication in his own possession. Because he had been interested in CBT in Preston, the team put him on the waiting list for the Coping with Anxiety and Low Mood (CALM) course at Dovegate.
34. On 12 October, Mr Jarvis made a request on the automated system to see someone to discuss his medication. He received a response on 16 October telling him that he had been booked to see the doctor on 14 November. The message said that if he felt that he needed to be seen sooner, he should speak to the nurse on his wing. If necessary, he or she could arrange for a more urgent appointment.
35. The following day, 17 October, Mr Jarvis submitted another automated request asking if he could once more hold his medication in his own possession. He said that he was struggling without it. The reply later that day explained that for the first 28 days in the prison he had to collect medication but could be assessed for in-possession status after that. The drug and alcohol treatment team assessed Mr Jarvis, and he told them that he had no concerns about substance misuse, and that he did not wish to engage with the service.
36. The same day Mr Jarvis told his offender supervisor, that he was interested in moving to Dovegate's therapeutic community. This is a separate part of the prison to help repeat serious offenders, offering daily group therapy. She provided some initial information there and then, and sent him an information pack and a referral pack the following day.
37. On 19 October, Mr Jarvis submitted another automated request to see the mental health team. He said that his anxiety and depression were getting worse. A Community Psychiatric Nurse replied electronically that Mr Jarvis was on the waiting list for the CALM group, and that if he had any immediate concerns he should see one of the nurses based on the wing.

38. On 26 and 29 October, Mr Jarvis made applications to speak to his offender supervisor about moving to a different wing and about a risk marker on his file. On 30 October, Mr Jarvis's offender supervisor replied that she would speak to him, and did so soon afterwards. (She did not note the date, and in interview said that she could not remember exactly when it was.) Mr Jarvis told her that he was not having any problems on the wing and was pleased that he had a job, but wanted to move to a more settled wing with long-term prisoners where he could engage with offending behaviour work. She said in interview that she had no concerns for his well-being.
39. On 1 November, Mr Jarvis made another automated application. He said that he had applied to see the mental health team but the mental health team had only put him forward for group therapy. He said that he did not need group therapy but wanted to see someone because he was struggling without his medication. A nurse replied that he should discuss any issues about medication with the GP, and encouraged him to attend the CALM course. She noted on his file that he appeared not to have been collecting his medication.
40. Mr Jarvis' medical record showed that he did not attend the CALM group on 6 November. The record indicated that he would be invited to the next session but he would be discharged from the group if he failed to attend again. A further note on his medical record by a pharmacist, noted poor compliance with his medication and that consideration should be given to stopping it.
41. On 7 November, Mr Jarvis submitted an automated message stating that he did not want group therapy. He said that if he could not have an individual consultation then he would manage his issues himself.
42. Cells in Dovegate have telephones installed for prisoners' use. On the evening of 8 November, Mr Jarvis telephoned his partner. He told her that he had not gone to work that day but had applied to go to the therapeutic community. His partner commented that he sounded down, and he said that he had been for a while.
43. Between 7.11am and 8.02am on 9 November, Mr Jarvis made a number of attempts to telephone his partner. When he did get through, she asked him to call back after two minutes. He did so and told her that he had been up all night. She said that she was busy at that moment and asked him to call back again. He called again at 8.10am and she asked him to call again in 10 minutes.
44. He telephoned her again at 8.13am. He told her that he had not gone to work. She told him that he should, and he replied that he might "string myself up" instead. She said that he could not do that because of her. He replied that it was not just her, it was "everything". She told him that they were both hurting, that she would still be his friend and would always be there for him, but it was not a normal relationship and that was why she had ended it. She said that neither of them knew what the future held, and she was not saying "never". She said that she had just completed a long shift at work and was tired. She asked him to telephone her at 4.00pm. He said that they should just "leave it". She said that he could call her later if he wanted to, and he replied: "You'll see, now you'll realise".

45. At 8.45am he called her again, and she again told him she was tired. She asked if he was going to call her later and told him to get some sleep. He did not reply and the call ended.
46. Mr Jarvis subsequently spoke to an officer about his application to move to the therapeutic community, and he signed the application form. Shortly after this there was a disturbance on the wing, in which Mr Jarvis was not involved, and all prisoners were returned to their cells. Staff conducted a roll count to ensure all prisoners were present and when he checked Mr Jarvis' cell he was sitting on the bed watching television.
47. Because of the disturbance, prison officers went on to conduct checks on all cells on the wing. At approximately 10.45am, two officers arrived at Mr Jarvis' cell and found him hanging. An officer called a code blue emergency (indicating a prisoner having difficulty breathing) and they went into the cell and lowered Mr Jarvis to the floor. The emergency call automatically triggered the control room to request an ambulance. Other staff, who were nearby conducting cell checks, also came to the cell. Prison officers began to perform cardiopulmonary resuscitation (CPR) in an attempt to revive Mr Jarvis. They were soon joined by medical staff and, after a short delay caused by problems with the radio communication, by the prison paramedic. They continued until ambulance paramedic staff arrived and took over. At 11.30am, Mr Jarvis was pronounced dead.

### **Contact with Mr Jarvis' family**

48. Staff identified Mr Jarvis' mother as his next of kin, and a family liaison officer and a senior prison manager went to her address and informed her of her son's death. In line with Prison Service guidance, Dovegate offered assistance with the costs of Mr Jarvis' funeral.

### **Support for prisoners and staff**

49. After Mr Jarvis' death, the prison Director, together with two of the prison's managers, debriefed the 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.
50. The prison posted notices informing other prisoners of Mr Jarvis' 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 Jarvis' death. Listeners (prisoners trained by the Samaritans to offer peer support) were posted to the wing. Mr Jarvis' best friend was in HMP Haverigg, and Dovegate staff contacted Haverigg to arrange for him to be informed.

### **Post-mortem report**

51. The post-mortem report showed that Mr Jarvis died as a result of hanging. Tests did not detect any illicit drugs in his system.

# Findings

## Assessment of risk

52. Mr Jarvis had been briefly monitored under ACCT procedures when he returned to prison in May 2017, but thereafter did not give any cause for concern that he might pose a risk to himself. When he received a long sentence in July, he accepted it and staff did not feel that he needed extra monitoring.
53. When he arrived in Dovegate in October, Mr Jarvis went through reception and induction procedures and did not give anyone reason to think he was at risk of harming himself. This remained the case through his four weeks in Dovegate. Although the investigation identified that he may have been having problems in his relationship with his partner and that he was struggling with depression, this was not known to prison staff. There is little evidence that wing staff engaged with Mr Jarvis to any great extent. His electronic prison record only records minimal contact.

## Mr Jarvis' healthcare

54. Mr Jarvis had no known physical health issues. On arrival at Dovegate he received an appropriate reception health screening which noted his history of anxiety, depression and self-harm. He was rightly referred to the mental health team for assessment.
55. However, we are concerned about the level of mental health support Mr Jarvis received. He contacted the healthcare team via the electronic system five times in four weeks, asking for help, making it clear that he was struggling and that his depression was getting worse. He was not seen in person on any of these occasions but received electronic replies. When Mr Jarvis made it clear that he did not want to be involved in group therapy, rather than visit him and explore his concerns or reassess his needs, healthcare staff replied on the electronic system, encouraging him to attend the group. No alternatives were raised or considered.
56. When Mr Jarvis expressed concerns about his medication, healthcare staff checked his records and replied electronically that he should speak to wing nurses or the GP. He was not seen in person. Healthcare staff noted that he had not been collecting his anti-depressant medication, but is no evidence that anyone asked Mr Jarvis why he had not been taking his medication.
57. The clinical reviewer noted that mental health staff did not believe that medication administration was their responsibility and did not liaise with primary care staff. Similarly, even though Mr Jarvis' medication related to his mental health, primary care staff did not alert the mental health team that he was not collecting it. When a pharmacist noted that Mr Jarvis was not collecting it, the note on his medical record suggests that his medication might be discontinued. There was no suggestion that someone should speak to him.
58. Following Mr Jarvis' death, the healthcare team have reviewed medication management. Lists of prisoners who do not collect their medication will be

compiled and brought to the daily meeting, when relevant staff will discuss it and take any necessary further action.

59. We are very concerned that healthcare staff relied exclusively on electronic communication with Mr Jarvis. The automated application system in use at Dovegate is an excellent resource to enable prisoners to book appointments, etc and ask for and receive factual information. However, Mr Jarvis was asking for help with his mental health concerns and we consider that he should have been seen in person. Given his history of depression and self-harm and the fact that he was not collecting his medication, it was not sufficient simply to keep telling him in writing to speak to a nurse on the wing. He should have been seen in person.
60. It is also a cause for concern that there is no evidence that anyone from healthcare told wing staff that Mr Jarvis had reported that he was struggling with depression. As a result, wing staff were not aware that Mr Jarvis might be vulnerable.
61. We make the following recommendations:

**The Head of Healthcare should ensure that when there appears to be an ongoing issue with a prisoner's medication, a member of staff should explore this with him in person.**

**The Head of Healthcare should ensure that when a prisoner reports significant health concerns via the electronic application system, he should be seen in person.**

**The Head of Healthcare should ensure that when a prisoner reports mental health concerns, healthcare staff should make wing staff aware.**

62. The clinical reviewer concluded that Mr Jarvis' healthcare in Dovegate was of mixed quality. While the primary care was equivalent to that he could have expected in the community, his mental healthcare was not.
63. The emergency response was appropriate, but we make a recommendation about the equipment available to the prison paramedic, which the Head of Healthcare should address.

### **Radio coverage**

64. The prison paramedic, said in interview that there are areas in Houseblock 3 where radio signals are lost. This includes the medication room where nurses and the prison's paramedic are sometimes stationed. This is obviously a cause for concern. When the emergency call went out on the radio, she did not hear it and only reacted on hearing a tannoy call for a doctor. On arriving at Mr Jarvis' cell she was told that nurses had been trying to contact her.
65. It seems likely that Mr Jarvis had died some time before the paramedic arrived at his cell. Medical staff had already arrived and were working to try to revive him. It is, therefore, unlikely that the delay had any effect on the outcome for Mr Jarvis. Nevertheless, it could do so in future cases. Since Mr Jarvis' death, the Head of Healthcare has arranged for a minimum of four healthcare staff to carry

radios while prisoners are unlocked, to reduce the risk of staff not hearing emergency calls. We hope that this is monitored for its effectiveness but are concerned that it does not address the underlying deficit and accordingly make the following recommendation:

**The Director and the Head of Healthcare should review radio coverage and ensure that there are adequate arrangements in place for staff who may be required in an emergency to be contacted without delay.**

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