

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Jarvis a prisoner at HMP Warren Hill on 30 December 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 Jarvis died of a heart attack, as a result of coronary heart disease, at HMP Warren Hill on 30 December 2015. Mr Jarvis was 49 years old. I offer my condolences to Mr Jarvis' family and friends.

I agree with the clinical reviewer that Mr Jarvis received a good standard of clinical care at Warren Hill. However, Mr Jarvis did not receive his blood pressure medication between February 2014 and September 2015, while at HMP Hull, and we can find no evidence that this was followed up. As a result, his care at these prisons fell short of 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2017

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Summary

Events

1. In December 1998, Mr Mark Jarvis was sentenced to life imprisonment for kidnapping, robbery and sexual offences. He spent time at several prisons and arrived at HMP Warren Hill on 18 November 2015.
2. Mr Jarvis suffered from high blood pressure, which doctors treated with ramipril (a medication that reduces high blood pressure). Treatment with ramipril began in 2010, though Mr Jarvis did not receive this medication between February 2014 and September 2015 while in the custody of HMP Hull. On 25 November, after moving to Warren Hill, prison doctors resumed Mr Jarvis' ramipril prescription, but decided to reduce his dosage because he had not taken the medication for over one year. Doctors intended to order blood tests, but the request for those tests was not entered on Mr Jarvis' record. As a consequence, these tests were not completed until after Mr Jarvis' next consultation with a doctor on 9 December. The tests showed abnormal liver function, but otherwise raised no clinical concerns.
3. Just before 8.00am on 30 December, an officer partially opened the door of Mr Jarvis' cell. The officer called to Mr Jarvis and briefly looked into the cell, before continuing unlocking the doors of other cells.
4. Later that day, at 11.07am, another officer found Mr Jarvis unresponsive in his cell. The officer called another officer for assistance, before radioing to healthcare for emergency medical support. A 'code blue' emergency call was issued after healthcare began responding to the initial radio call. Healthcare staff arrived at 11.12am and confirmed that Mr Jarvis had died. A post-mortem showed that Mr Jarvis died of sudden dysrhythmia (a heart attack) as a result of ischaemic heart disease.

Findings

5. We are satisfied that Mr Jarvis received appropriate treatment for his blood pressure at Warren Hill. However, we agree with the clinical reviewer's conclusion that his blood pressure treatment at Hull fell short of the standard of healthcare he could expect to receive in the community.
6. On the morning of Mr Jarvis' death, we are concerned that the officer who unlocked his cell did not check on Mr Jarvis' wellbeing appropriately because he did not open the door wide enough and could not be sure that Mr Jarvis had responded.
7. When officers discovered Mr Jarvis, they concluded immediately that he had passed away and decided that resuscitation should not be administered. We are satisfied that this was the appropriate decision.

Recommendations

- The Head of Healthcare at HMP Hull should ensure that high blood pressure is promptly and appropriately investigated and treated in line with current clinical guidelines.
- The Governor at HMP Warren Hill should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Warren Hill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Jarvis' prison and medical records.
10. NHS England commissioned a doctor to review Mr Jarvis' clinical care at the prison.
11. The investigator, one of the Ombudsman's managers, and the doctor interviewed five members of staff at Warren Hill on 25 May 2016. The investigator interviewed another member of staff by telephone on 14 July.
12. We informed HM Coroner for Ipswich of the investigation. Our investigation was suspended for nearly seven months until we received the post-mortem report from the coroner. We regret the consequent delay in issuing this report. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Jarvis' sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked us to investigate whether officers had checked on Mr Jarvis appropriately and whether he should have been discovered sooner. She also asked us to review how the prison treated his heart palpitations and high blood pressure, and whether Mr Jarvis had appropriate healthcare for these.
14. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.
15. Mr Jarvis' family received a copy of the initial report. The solicitor representing Mr Jarvis' family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Warren Hill

16. HMP Warren Hill is a medium secure prison that holds nearly 260 men. For many years, the prison held boys aged between 15 and 18 years of age, although in September 2013 the prison population changed to include only adult men serving life sentences.
17. Care UK provides healthcare services. Nurses are on duty between 7.30am and 7.45pm during the week, and 7.30am to 5.30pm on weekends and public holidays. Nurses provide regular clinics for chronic conditions, substance misuse and mental health. Doctors consult at the prison from 10.45am to 1.00pm on Monday to Friday.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Warren Hill was in October 2015. Inspectors reported that some clinics for prisoners with chronic conditions were conducted by nurses who did not have appropriate training and that care planning for prisoners with chronic conditions and complex health needs, needed more development. Inspectors recommended training more staff in first aid, developing evidence-based care plans for complex health needs, and ensuring prisoners with lifelong conditions receive regular reviews by appropriately trained staff.

Independent Monitoring Board

19. 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 May 2016, the IMB reported that overall the medical provision at the prison was at least as good as in the community. They found that many prisoners had long term medical conditions, with over 50% of the population receiving regular medication, although the healthcare team were trying to reduce the dependency on medication.

Previous deaths at HMP Warren Hill

20. Mr Jarvis was the first prisoner to die from natural causes at Warren Hill. Another prisoner has died from natural causes at the prison since Mr Jarvis' death.

Key Events

21. In December 1998, Mr Mark Jarvis was sentenced to life imprisonment for kidnapping, robbery and sexual offences. He spent time at several prisons, including HMP Hull and HMP North Sea Camp, before being transferred to HMP Warren Hill on 18 November 2015.
22. Mr Jarvis suffered from gastric reflux, irritable bowel syndrome, chronic shoulder pain and hypertension (high blood pressure). He was a smoker but, despite regular smoking cessation advice, he did not stop smoking.
23. In 2010, prison healthcare staff noted that Mr Jarvis suffered with hypertension (high blood pressure), which they treated with ramipril (a medication that reduces high blood pressure). However, between February 2014 and September 2015, while at Hull, Mr Jarvis did not receive this medication. Mr Jarvis' medical record does not explain why this medication stopped.
24. In 2010, a doctor warned Mr Jarvis that stopping a prescription for propranolol (normally used to treat high blood pressure and angina, but prescribed in this circumstance to prevent anxiety) may cause a sensation that his heart was racing, although this would fade over several days. Following this, healthcare staff often checked Mr Jarvis' pulse and found that it was normal.
25. A nurse carried out an initial health screen with Mr Jarvis when he arrived at Warren Hill. She noted that he suffered from pain in his right shoulder associated with a long-term injury and measured his blood pressure at 140/105 (readings of above 140/90 are considered high). Mr Jarvis told the nurse that clinicians had advised him to monitor his blood pressure, and she scheduled an appointment to re-examine his blood pressure the following week.
26. On 23 November, a nurse measured his blood pressure at 153/96 and made a note to monitor his blood pressure regularly. There were no other blood pressure readings taken during his time at Warren Hill.
27. During a consultation with a doctor, on 25 November, Mr Jarvis complained of bowel problems, stomach pain and chronic shoulder pain. Mr Jarvis did not discuss treatment for his high blood pressure during the consultation. However, as the consultation ended a prison nurse queried his treatment with ramipril. The doctor observed that Mr Jarvis had not taken ramipril while at the previous prison, and decided to reduce the dosage from 10mg to 2.5mg daily.
28. The doctor reviewed Mr Jarvis on 9 and 24 December and, on both occasions, prescribed pregabalin (a pain reliever) for his shoulder pain and ramipril.

30 December 2015

29. Just before 8.00am on 30 December, an officer unlocked the door of Mr Jarvis' cell. CCTV footage showed that the officer partially opened the door, looked into the cell and then continued unlocking the doors of other cells. The officer said that he called to Mr Jarvis, though he could not be sure that he had seen Mr Jarvis alive or heard him respond.

30. At 11.07am, another officer visited Mr Jarvis' cell. He entered the cell and found Mr Jarvis unresponsive, seated in front of the television, with his head tilted back and eyes open. The officer told us that upon entering the cell he saw that Mr Jarvis' skin was mottled purple and concluded immediately that Mr Jarvis had passed away. The officer left the cell, ran down a flight of steps and called to a senior officer for assistance.
31. The senior officer arrived approximately 20 seconds later and the two officers entered the cell. The senior officer said that when he entered the cell he saw that Mr Jarvis' head was titled very far back, his eyes and mouth were open, and blood had pooled in his hands and feet. He shook Mr Jarvis and noted that his arm was stiff. They both agreed that Mr Jarvis was dead and therefore decided to seal the cell. One of the officers called for medical assistance, although a code blue emergency (which indicates that a prisoner is unconscious or not breathing) was not called.
32. Another officer arrived shortly after and suggested placing Mr Jarvis' body on the floor to resuscitate him. The senior officer decided not to do this because he felt that Mr Jarvis was clearly dead.
33. Two nurses responded to the initial radio call and, when travelling to the cell, one of the nurses asked whether it was a code blue emergency. The senior officer confirmed that it was and called the code blue. One of the nurses also said that an ambulance should be called when told that this had not happened. The control room called an ambulance at 11.15am.
34. The nurses arrived at Mr Jarvis' cell at 11.12 am. One of the nurses checked Mr Jarvis' body for signs of life and agreed that resuscitation should not start. She said that livor mortis (discolouration of the skin due to the pooling of blood) was present and she thought that he had been dead for around six hours.
35. At 11.30am, a doctor arrived and examined Mr Jarvis. She declared Mr Jarvis dead a few minutes later at 11.36am. Paramedics arrived at 11.40am.

Contact with Mr Jarvis' family

36. At around 1.50pm on the day Mr Jarvis died, the prison contacted local police to confirm the home address for his sister, his nominated next of kin. An hour later, a senior prison manager and a prison chaplain left Warren Hill to visit Mr Jarvis' sister. They arrived at her address at 6.00pm and told her of Mr Jarvis' death. They also offered their condolences and support. The senior prison manager maintained contact with Mr Jarvis' sister for the next three weeks to assist with arrangements for the funeral and the return of Mr Jarvis' property.
37. Mr Jarvis' funeral was held on 22 January and the prison contributed towards the funeral costs, in line with Prison Service Instructions.

Support for prisoners and staff

38. After Mr Jarvis' death, the Governor 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.

39. The prison posted notices informing other prisoners of Mr Jarvis' death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Jarvis' death.

Post-mortem report

40. A post-mortem examination found that Mr Jarvis died of sudden dysrhythmia (a heart attack) as a result of ischaemic heart disease.

Findings

Clinical care

41. On arrival at Warren Hill, clinicians identified Mr Jarvis' blood pressure problems and began caring for his condition appropriately. On 25 November, one week after arriving, he saw a GP and was restarted on a lower dose of ramipril, the blood pressure medication that doctors at previous prisons prescribed to treat his high blood pressure. At interview, the doctor told us that, although high, his blood pressure did not raise significant concerns, and because Mr Jarvis had not taken the ramipril for over one year, it was appropriate to reduce the dosage. The doctor intended to order tests of Mr Jarvis' urine, electrolyte and liver but she did not enter the request for blood samples in his medical record. As a consequence, the tests were not completed until after Mr Jarvis' next consultation with the doctor on 9 December. The blood tests were taken on 11 December and discussed with Mr Jarvis on 24 December. The results indicated possible issues with Mr Jarvis' liver function, but otherwise raised no clinical concerns. The doctor scheduled repeat liver tests a month later, but Mr Jarvis died before the tests could be repeated. The clinical reviewer agreed that the decision to reduce Mr Jarvis' dose of ramipril, and the response to the results of his liver test were appropriate decisions, in line with clinical practices in the community.
42. However, the management of Mr Jarvis' blood pressure at previous prisons was poor. After prison clinicians diagnosed high blood pressure in October 2010, Mr Jarvis started on ramipril and the dose gradually increased. From April 2011, he began taking ramipril regularly. He was moved to Hull in February 2014, but did not receive the medication during his time at these prisons. He resumed taking the medication regularly after arriving at Warren Hill in November 2015. We found no evidence to indicate why this occurred. We note that clinicians at Hull created a care plan for his blood pressure on 30 April 2014, but did not implement the plan with Mr Jarvis. There are no other records of treatment or monitoring of his blood pressure during his time at Hull.
43. We agree with the clinical reviewer that, overall, treatment of Mr Jarvis' blood pressure would have been better in the community. We make the following recommendation:

The Head of Healthcare at HMP Hull should ensure that high blood pressure is promptly and appropriately investigated and treated in line with current clinical guidelines.

Unlock procedures

44. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that:

"Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

45. Prison Service Instruction (PSI) 75/2011 also states that:

“There need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”

46. When clinicians attended Mr Jarvis’ cell, they noted the presence of rigor and livor mortis, with a nurse suspecting that he had been dead for around six hours. We believe that this demonstrates that Mr Jarvis was not alive when an officer unlocked his cell.

47. The officer could not remember unlocking Mr Jarvis’ cell. CCTV footage shows that he opened the door partially without entering the cell. At interview, the officer acknowledged that it was possible he mistook the sound of the television for a verbal response from Mr Jarvis.

48. The officer also told us that he has since changed his unlock procedures to ensure a visual check on prisoners. While we are satisfied that the officer has changed his working practices, we are concerned that this practice needs to be consistent in Warren Hill. Therefore, we make the following recommendation:

The Governor at HMP Warren Hill should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency procedures

49. After discovering Mr Jarvis’ body, an officer did not radio a code blue emergency. This did not happen until after a nurse queried the nature of the emergency response. After the code blue was called, the control room did not automatically call an ambulance and the nurse needed to confirm that one was needed.

50. The emergency response did not affect the overall outcome for Mr Jarvis or cause significant delays to healthcare’s response and we are satisfied that it was clear that any medical intervention would have been fruitless. We therefore make no recommendation.

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