Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr John Jarvis, a prisoner at HMP Isle of Wight, on 25 April 2019

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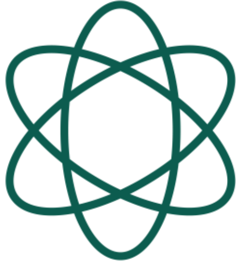
# Our vision

**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

OGL

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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 John Jarvis died on 25 April 2019 of heart failure and heart disease while a prisoner at HMP Isle of Wight. He was 92 years old. I offer my condolences to Mr Jarvis' family and friends.

I am satisfied that the standard of healthcare Mr Jarvis received at Isle of Wight was equivalent to that which he could have expected to receive in the community.

However, I am concerned that when Mr Jarvis fell in his cell on 5 April, prison staff did not use an emergency code to indicate that there was significant blood loss. The clinical reviewer was, however, satisfied that this did not affect the outcome for Mr Jarvis.

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** **October 2020**

# Contents

Summary ........................................................................................................................1

The Investigation Process..................................................................................................2

Background Information....................................................................................................3

Key Events.........................................................................................................................4

Findings ..............................................................................................................................6

# Summary

## Events

1. On 19 September 2014, Mr John Jarvis was sentenced to 20 years in prison for sexual offences. He was transferred to HMP Isle of Wight on 2 November 2015.

2. Mr Jarvis was an older prisoner with several chronic health problems. Healthcare staff created care plans to manage his health conditions and reviewed him regularly.

3. On 5 April 2019, Mr Jarvis fell over in his cell. Prison staff called for healthcare assistance. When a nurse arrived, she requested an emergency ambulance and Mr Jarvis was taken to hospital. Hospital staff diagnosed Mr Jarvis with a fractured arm.

4. On 18 April, Mr Jarvis fell over again in his cell. He was taken to hospital by emergency ambulance and was diagnosed with a fractured shoulder blade. On his return from hospital to the prison's inpatients unit, healthcare staff completed a comprehensive review and completed hourly observations.

5. On 20 April, healthcare staff found Mr Jarvis unwell. They staff arranged for him to go to hospital. Hospital staff diagnosed Mr Jarvis with dehydration due to an acute injury to his kidneys and treated him with intravenous infusions.

6. Mr Jarvis' condition deteriorated and at 9.24pm on 25 April, it was confirmed that Mr Jarvis had died.

7. The post-mortem report gave Mr Jarvis' cause of death as cardiac failure and heart disease.

## Findings

8. The clinical reviewer found that the standard of healthcare that Mr Jarvis received at Isle of Wight was equivalent to that which he could have expected to receive in the community. Healthcare staff appropriately assessed his clinical needs and referred him to hospital when necessary.

9. Prison staff did not use an emergency medical code when Mr Jarvis fell in his cell on 5 April. The clinical reviewer is satisfied, however, that this did not affect the outcome for Mr Jarvis.

# The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr Jarvis' prison and medical records.

12. NHS England commissioned an independent clinical reviewer to review Mr Jarvis' clinical care at the prison.

13. We informed HM Coroner for Isle of Wight of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Jarvis' next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Jarvis' next of kin said that she wanted to know the details of Mr Jarvis' care before his hospital admission. This has been addressed in this report.

15. Mr Jarvis' family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed in this report.

16. The initial report was shared with the Prison Service as part of the consultation process.

17. The Prison Service provided further information about events when Mr Jarvis fell in his cell. We have amended our report to acknowledge and take account of the additional information.

# Background Information

## HMP Isle of Wight

18. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners with a wide range of health needs. The inpatient unit includes special facilities for end of life care.

## HM Inspectorate of Prisons

19. The most recent inspection of HMP Isle of Wight was in April and May 2019. Inspectors reported that health services were very good. Physical health care was effective across both sites, with nurse triage and emergency GP appointments available on weekdays, and access to long-term condition clinics. Routine GP consultations and visiting specialists were equivalent to the community. The inpatient unit provided safe and effective care, delivered by suitably trained and supported clinical staff.

## Independent Monitoring Board

20. 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 31 December 2018, the IMB reported that the prison's healthcare unit was a well-run and well-led organisation which provided a standard of care at least equal to that provided for the general public. The IMB noted that the manager had changed mid-year and the new manager had continued to maintain the same high standard, ensuring that staff remained positive and well-motivated.

## Previous deaths at HMP Isle of Wight

21. Mr Jarvis was the 19th prisoner to die at HMP Isle of Wight since April 2017. Of the previous deaths, 14 were from natural causes and three were self-inflicted deaths. There are no similarities between our investigation findings in Mr Jarvis' case and those in previous deaths.

## Key Events

22. On 19 September 2014, Mr John Jarvis was sentenced to 20 years in prison for sexual offences. He was sent to HMP Manchester. Mr Jarvis' medical history included an abdominal aortic aneurysm repair, cataract removal, shoulder and knee replacement, an arterial bypass in his leg, a facial fracture and a kidney removal.

23. On 2 November 2015, Mr Jarvis was transferred to HMP Isle of Wight. Because of his medical conditions, healthcare staff saw Mr Jarvis regularly. Over time Mr Jarvis' health deteriorated and he developed more chronic health conditions, including mild vascular dementia, dizziness and vertigo, heart disease, inflammation of his ribs/sternum, gall bladder inflammation, a fractured shoulder blade and diarrhoea resulting in acute kidney injury (a medical term for loss of kidney function which can happen as a complication of other illnesses and is not the result of a physical blow to the kidneys, as the name might imply).

24. Mr Jarvis had regular tests to monitor his conditions and healthcare staff reviewed and adjusted his medications as required. From December 2016, a consultant in Old Age Psychiatry diagnosed mild vascular dementia which did not require any treatment.

25. On 3 January 2019, wing staff were concerned about Mr Jarvis and asked a nurse to examine him. She was concerned that his oxygen saturation level was low so arranged for an ambulance to take him to hospital.

26. Hospital staff diagnosed a chest infection with possible biliary sepsis. Mr Jarvis was treated with intravenous antibiotics for six days. Mr Jarvis also complained of abdominal pain and hospital staff diagnosed cholecystitis (gall bladder inflammation) and a heart attack. Hospital staff decided Mr Jarvis was not fit for surgery so they discharged him from hospital and he was returned to prison.

27. On 10 January, prison staff noted that Mr Jarvis appeared confused and unable to care for himself. He was moved to the prison's inpatients unit to receive increased nursing care. Mr Jarvis told a nurse that he felt weak and unable to stand unaided. The nurse arranged for a prison GP to review him. A prison GP examined Mr Jarvis and noted that his health was deteriorating due to his old age and asked healthcare staff to ensure he was comfortable. Mr Jarvis said that he was not in pain or discomfort.

28. On 11 January, the prison started the process of applying for early release on compassionate grounds on Mr Jarvis' behalf. However, staff struggled to find suitable accommodation for him in the community and Mr Jarvis died before the application process could be completed.

29. On 5 April, Mr Jarvis fell in his cell. He had injured his head and was bleeding. Wing staff requested healthcare assistance. They did not radio an emergency code red (indicating significant blood loss). A nurse attended and requested an emergency ambulance. Mr Jarvis was taken to hospital. He was escorted by two officers, but he was not restrained.

30. Hospital staff diagnosed Mr Jarvis with an arm fracture. He received treatment and was discharged from hospital and returned to the prison the following day.

31. On 18 April, Mr Jarvis had another fall in his cell. A nurse arranged for him to go to hospital. Hospital staff diagnosed a fractured left shoulder blade and made an outpatient appointment for him. On return to the prison's inpatients unit, healthcare staff completed a comprehensive review and a falls risk assessment because Mr Jarvis was frail.

32. On 20 April, Mr Jarvis told a nurse that he had a sore throat. He noted that Mr Jarvis had an area of pus in his mouth, vomited and had diarrhoea. He arranged for a non-emergency ambulance to take Mr Jarvis to hospital. Hospital staff conducted blood tests and diagnosed Mr Jarvis with dehydration due to an acute injury to his kidneys, caused by a lack of fluids. Mr Jarvis was treated with intravenous infusions.

33. Mr Jarvis' condition continued to deteriorate and at 9.24pm on 25 April, it was confirmed that Mr Jarvis had died in hospital.

## Contact with Mr Jarvis' family

34. On 3 January 2019, the prison appointed two senior officers as the family liaison officers. They visited Mr Jarvis regularly during his hospital admissions. Mr Jarvis said that his daughter was his nominated next of kin.

35. After Mr Jarvis fell in his cell and fractured his shoulder on 5 April, an officer rang and updated Mr Jarvis' next of kin.

36. After Mr Jarvis died, a family liaison officer rang Mr Jarvis' next of kin to inform her of his death and to offer the prison's condolences and support.

37. Mr Jarvis' funeral was held on 30 May. The prison paid for Mr Jarvis' funeral in line with prison guidance.

## Support for prisoners and staff

38. After Mr Jarvis' death, a duty manager debriefed the escorting staff 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 assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Jarvis' death.

## Post-mortem report

40. The post-mortem report gave Mr Jarvis' cause of death as cardiac failure, ischaemic heart disease (heart problems due to narrowed arteries) and chronic myocarditis (inflammation of the heart muscle). He also had chronic obstructive pulmonary disease (lung disease) and chronic kidney disease, which did not cause, but contributed to his death.

# Findings

## Clinical care

41. The clinical reviewer concluded that the clinical care Mr Jarvis received at the Isle of Wight was equivalent to that which he could have expected to receive in the community.

42. When Mr Jarvis arrived at the prison, he was 89 and had a number of chronic health problems. He gradually became frailer and developed a number of additional chronic conditions, including heart disease, kidney disease and mild dementia. The clinical reviewer found that healthcare staff at Isle of Wight appropriately reviewed and managed these conditions.

43. We make no recommendations.

## Compassionate release

44. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and a life expectancy of less than three months.

45. The prison started the process to apply for early release on compassionate grounds on Mr Jarvis' behalf. However, staff struggled to find suitable accommodation for him and he died before the application process could be completed. We are satisfied that the prison appropriately considered compassionate release.

46. We make no recommendation.

## Emergency response

47. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. It states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The PSI makes it clear that there should be no delay in admitting and discharging an ambulance.

48. When Mr Jarvis fell in his cell on 5 April, staff did not call an emergency radio code red to indicate he was bleeding. Instead, they asked for healthcare assistance. When healthcare staff arrived, the nurse requested an ambulance. There was also a slight delay in calling an ambulance. As the clinical reviewer was satisfied that the delay did not affect the outcome for Mr Jarvis, we do not make a recommendation in this instance.

## Comments received after the initial report

49. The Prison Service explained that in their opinion the policy, and the report, state that a code red should be called in the event of significant blood loss. However, they said that it was not the case for Mr Jarvis. They also said falls do not in themselves require the calling of a code and are also not covered in the PSI as a medical emergency.

50. The Prison Service also said that the report suggests that the nurse in attendance was critical of the decision not to call a code, however this was a misunderstanding of her notes. They said she had confirmed that in stating “Not code blue or red” she meant that the incident did not require a code, and it was her concern around Mr Jarvis’ shoulder mobility that led to her summoning an urgent (as opposed to emergency) ambulance. She did not consider the blood loss to be sufficient to require a code red.

51. The Prison Service said it was their view that staff acted appropriately. We have amended the report to reflect their comments.

52. Mr Jarvis’ family also had comments. They wanted to know why the family were not contacted on 14 April and their calls on 15 April were never returned. From the prison records there would not have been a specific reason for the prison to contact Mr Jarvis’ family as they had provided an update on 7 April. Regrettably, it appears that no one noted their contact with the prison on 15 April.

53. The family asked why they were not contacted about compassionate release. The records note that prison staff were trying to arrange suitable accommodation and noted that there appeared to be no family members who were willing to assist in his resettlement care and therefore any care would have to be provided by professional staff and agencies.

54. Mr Jarvis’ family asked why was he “badly dehydrated” if he was in the healthcare unit? The clinical reviewer said that there was no evidence he was "badly dehydrated". He had vomited and had diarrhoea, and this could lead to dehydration. The clinical reviewer said that Mr Jarvis was promptly admitted to hospital once the vomiting and diarrhoea started.

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