

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Jarvis a prisoner at HMP YOI Stoke Heath on 15 December 2016

**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.

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

Mr Paul Jarvis died on 15 December 2016. It is very likely that he took a new psychoactive substance at HMP Stoke Heath before falling ill, although the pathologist could not ascertain the cause of death. Mr Jarvis was 55 years old. I offer my condolences to Mr Jarvis' family and friends.

The prison has a proactive drug strategy. However, prisoners told us that drugs are still easily available to those who want them and we consider that Stoke Heath need to revisit the measures they have in place to see if more can be done. They should also ensure that prisoners suspected of having taken psychoactive substances are appropriately monitored. We also identified areas for improvement in family liaison.

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
Acting Prisons and Probation Ombudsman

November 2017

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Summary

Events

1. Mr Paul Jarvis was arrested on 3 March 2015. His licence from a previous sentence was revoked and on 8 June he was sentenced to a further 6 years for burglary. On 28 August 2015, Mr Jarvis transferred to HMP Stoke Heath and for most of his time in the prison lived on the drug treatment and recovery wing. Officers told us that prisoners accused Mr Jarvis of being too close to staff. In addition to methadone prescribed by the substance misuse service, Mr Jarvis was prescribed medication for anxiety and depression by a psychiatrist.
2. In May 2016, Mr Jarvis' cell was searched and burnt pieces of foil were found (suggesting drug use), so he was put onto closed visits. Security intelligence recorded on 12 December alleged that some cleaners were helping themselves to extra food portions and smoking Mamba (a new psychoactive substance). Mr Jarvis was a cleaner at that time, although no prisoners were named in the intelligence.
3. On 14 December, a prisoner told officers that Mr Jarvis was being sick in his cell. Mr Jarvis said he had smoked something. Two nurses assessed Mr Jarvis and decided he did not need an ambulance. One of the nurses said she asked officers to check him every 15 minutes. Staff were less clear about what they had been told. In any event, it was not made explicit which member of staff would do the checks and over the next 45 minutes none were made.
4. Around 3.00pm, prisoners told a nurse and officer that Mr Jarvis was unwell again. Nurses took observations and continued to monitor Mr Jarvis over the next 15 minutes, but there was no change or improvement. The prison called an ambulance and the paramedics took Mr Jarvis to hospital. The escorting staff described Mr Jarvis as being in a "trance", but then suddenly violent. At about 1.10am, hospital staff gave Mr Jarvis a dose of diazepam (used as a sedative). By 1.30am, Mr Jarvis was quiet, but shortly before 2.00am one of the officers became concerned that he could not see his chest rising. They alerted a nurse, but hospital staff could not resuscitate Mr Jarvis and he was pronounced dead at 2.35am. Mr Jarvis' family contact details were not up to date and the prison did not notify them of his death until 10.00am that morning.
5. The pathologist could not ascertain a cause of death. Toxicology tests found Mr Jarvis' prescribed medication, but no psychoactive substances in blood or urine samples. However, traces of a psychoactive substance were found in some items taken from Mr Jarvis' cell (cigarette ends and rolled cigarettes).

Findings

6. Stoke Heath should ensure staff clearly communicate the frequency of follow up staff checks when a prisoner is suspected of taking drugs, who will make those checks and where they will be recorded.
7. Although we think Stoke Heath have good measures in place to reduce the availability of drugs, it is likely that Mr Jarvis smoked a psychoactive substance shortly before becoming unwell. Stoke Heath should review its policy to see if

further measures can be taken to reduce the supply of and demand for drugs and to emphasise the risk of trading prescribed medication.

8. There was a delay in notifying Mr Jarvis' daughter of his death. Keeping next of kin information up to date is important. There should be annual requests for prisoners to provide updates or confirmation that nothing has changed.

Recommendations

- The Governor and Head of Healthcare should ensure that when a prisoner is suspected of having taken a psychoactive substance or other drug, there is clear communication between healthcare and officers about follow up monitoring, checking and recording of the prisoner's well being.
- The Governor should review the drug reduction strategy to help reduce further the supply of and demand for new psychoactive substances, to ensure that staff are vigilant to signs of its use, and to emphasise the risks from the trade of prescribed medication.
- The Governor should ensure that annual updates of next of kin details including name, telephone numbers and addresses are requested from prisoners and noted in their NOMIS prison record.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Stoke Heath informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. NHS England commissioned a clinical reviewer to review Mr Jarvis' clinical care at the prison.
11. The investigator visited Stoke Heath on 22 December 2016 and met the Governor, Deputy Governor, Head of Safer Custody and Head of Security. She obtained copies of relevant extracts from Mr Jarvis' prison and medical records.
12. The investigator interviewed 15 members of staff and six prisoners at Stoke Heath in January and February. The clinical reviewer joined her for interviews with four staff.
13. We informed HM Coroner for Shropshire, Telford and Wrekin of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Jarvis' daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked why the prison did not have up to date contact details for Mr Jarvis' family and said they were not told what had happened until 10.00am on 15 December. Mr Jarvis' daughter asked for details about the response when her father became unwell, his level of monitoring and when paramedics arrived to take him to hospital.
15. Mr Jarvis' family received a copy of the initial report. They had no further comments or questions about the report but wished to raise some matters at the inquest.
16. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP YOI Stoke Heath

17. HMP & YOI Stoke Heath is a medium security prison in Shropshire holding up to 782 adult and young adult men. Primary care services are provided by Shropshire Community Health NHS Trust and secondary mental health services by South Staffordshire NHS Foundation Trust.

HM Inspectorate of Prisons

18. The most recent inspection of Stoke Heath was in April 2015. Inspectors reported that levels of violence were high and likely to be linked to the availability of alcohol and drugs, including new psychoactive substances. Inspectors felt many prisoners were under-occupied and boredom contributed to poor behaviour.
19. Inspectors assessed relationships between staff and prisoners as a strength and said, overall, Stoke Heath had weathered the pressures on the prison system better than most prisons.

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 April 2016, the IMB reported that they continued to be concerned about the national problem of the use and availability of new psychoactive substances in the prison estate. They felt some incidents in the prison were 'fuelled' by these substances.

Previous deaths at HMP Stoke Heath

21. There have been three other deaths at Stoke Heath since 2013. In one of these deaths the prisoner is thought to have taken a new psychoactive substance.

New Psychoactive Substances (NPS)

22. 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.
23. In July 2015, we published a Learning Lessons Bulletin about the use of 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 NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

24. 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. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

25. Mr Paul Jarvis breached the terms of his licence from a previous sentence, so was recalled to prison on 3 March 2015 and faced further charges for burglary. On 8 June, he was sentenced to 6 years for the additional charges. Staff assessed Mr Jarvis as at risk of suicide and self-harm so started suicide prevention measures on 21 June, but stopped the measures the next day.
26. On 28 August 2015, Mr Jarvis transferred to Stoke Heath. Over the next few weeks, substance misuse staff twice agreed to increase his dose of methadone (an opiate substitute), as he said he was struggling. Towards the end of September, Mr Jarvis tested positive for methadone and subutex (a semi-synthetic opioid) and told staff he had taken subutex because he was struggling to cope. His dose of methadone was increased again. A month later Mr Jarvis asked for his dose to be increased again, but this request was refused. On 26 October 2015 he moved to B Wing, the drug treatment and recovery wing at Stoke Heath.
27. In addition to the methadone prescribed by the substance misuse service, Mr Jarvis was prescribed pregabalin (for anxiety), quetiapine (for major depressive disorder) and mirtazapine (an antidepressant) by the psychiatrist.
28. The named officer for Mr Jarvis told us that Mr Jarvis got a job as a cleaner on the wing. He said he knew Mr Jarvis well and they spoke frequently, although he said he had not made monthly entries in Mr Jarvis' case notes as required because he was too busy on the wing. Another officer described Mr Jarvis as very polite. Some prisoners accused him of being "too close knit" with staff (he did give some information to staff about mobile phones and drugs). All of the prisoners we spoke to on B Wing were complimentary about the officers who worked with them and said they were approachable and supportive.
29. On 8 February 2016, the substance misuse team met Mr Jarvis and he agreed to do some individual work with a drug and alcohol practitioner around managing emotions. Mr Jarvis said his brother had recently died and his daughter had been having problems with her partner. He said he was finding things difficult and that he had used heroin a few days earlier. The substance misuse GP subsequently agreed to increase Mr Jarvis' methadone again.
30. On another occasion, 25 February, the substance misuse GP increased Mr Jarvis' methadone prescription to 15mls, after Mr Jarvis told the substance misuse team he felt he might relapse and start taking other drugs. When the drug and alcohol practitioner met Mr Jarvis on 10 March, he said he was feeling settled and calmer. His methadone prescription continued at 15mls per day.
31. On 18 May, another prisoner alleged that Mr Jarvis had received drugs during a visit. Mr Jarvis' cell was searched and burnt pieces of foil were found (suggesting drug use). Mr Jarvis was put onto closed visits on 24 May (where the prisoner is kept on one side of a screen to prevent contact with their visitors) and these continued until 8 September.
32. On 26 May, a psychiatrist met Mr Jarvis and reviewed his medication. At the follow up review a month later, Mr Jarvis said he felt significantly better and less

anxious. At a review of his methadone prescription on 18 August, Mr Jarvis agreed to begin to reduce his dose by 1ml every four weeks.

33. On 17 and 22 November, Mr Jarvis met members of the substance misuse team and they decided to continue his slow reduction of methadone until the New Year.
34. Mr Jarvis took two paracetamol tablets on 9 December, four on 10 December and another four tablets the next day. The reason was not recorded in the SystmOne medical record, although nurses told us that it should have been. Some prisoners told us Mr Jarvis had smoked Mamba (a new psychoactive substance) around this time. They said it made him feel unwell and he had missed work as a result.
35. On 10 December, the Head of Security and Intelligence said a drug dog searching for 'hooch' (illicit alcohol) indicated outside Mr Jarvis' cell and, as a result, it was due to be searched on 14 December. Security intelligence written on 12 December alleged that some cleaners were helping themselves to extra food portions and smoking Mamba. (Mr Jarvis was a cleaner.)
36. On Sunday 11 December, nurses went to Mr Jarvis' cell to check that the amount of medication in his cell was correct and that he was taking his "in-possession" medication (lansoprazole, mirtazapine, paracetamol and quetiapine) correctly. Nurses were content that Mr Jarvis had the expected amount of medication left in his cell.
37. Mr Jarvis made regular telephone calls to his two daughters and spoke to one or both of them on 10, 11, 12 and 13 December. They spoke about some family matters and arranging to visit Stoke Heath. Mr Jarvis was looking forward to their next visit.

14 December 2016

38. We watched CCTV footage of Mr Jarvis' landing on 14 December 2016. A prisoner was unlocked for work around 2.00pm, but returned a short time later and looked briefly into Mr Jarvis' cell before talking to another prisoner through his cell door (His cell was directly opposite Mr Jarvis' cell.)
39. The prisoner asked the prisoner who was unlocked to ask Mr Jarvis if he could borrow a cigarette. He saw Mr Jarvis sitting on the bed, being sick. He hesitated because he did not want to get Mr Jarvis into trouble by alerting staff unnecessarily. He looked again and decided he had to get staff's help, so ran into the wing office to alert staff. Three officers went to Mr Jarvis' cell and an officer radioed to ask for a nurse and the prison's duty manager. The control room timed this radio message at 2.09pm. The officer said she asked Mr Jarvis if he had taken something and he replied, "I only had three puffs", but did not say what it was he had taken.
40. Staff arrived, including the prison duty manager. Two nurses assessed Mr Jarvis and said he was alert, vomiting and wanted to sleep things off. His clinical observations were fine and they did not think he needed an ambulance. Mr Jarvis said he had smoked "two puffs of something". One nurse told us that she was worried that Mr Jarvis might vomit again and could choke, and she therefore

asked the officers to look at him every 15 minutes to make sure he was alright. She said she told them to call her back if he vomited or deteriorated.

41. All the staff left Mr Jarvis' cell and his door was locked. An officer told us she remembered the nurse speaking to the duty manager, who then instructed three officers to check Mr Jarvis in approximately 20 minutes to half an hour. If he had not recovered, the nurses would come back. She said it was not clear who would do the checks. The duty manager said he did not remember the nurse giving a defined time for the checks, just that they should "keep an eye on him" and the nurse would return later.
42. Over the next 45 minutes, no officer or nurse checked Mr Jarvis. Several prisoners looked into Mr Jarvis' cell.
43. Around 3.00pm, a nurse was assessing another prisoner on B Wing and as she came out of that person's cell, two prisoners asked her to check Mr Jarvis. At the same time another prisoner told officers that Mr Jarvis was unwell again. The nurse said Mr Jarvis had been sick on the floor, but was sitting up against the bed. He was very pale and did not seem fully aware of what was happening. They helped Mr Jarvis back onto his bed and put him in the recovery position.
44. An officer radioed for "first response" and the black bag (containing equipment for respiratory problems such as oxygen and the defibrillator) on the nurse's behalf (she did not have a radio) at 3.09pm. Two more nurses made their way to Mr Jarvis' cell.
45. When one nurse arrived she said Mr Jarvis was still alert and able to answer her but she gave him oxygen because he looked very pale. The nurses took observations, which were all within the normal range. They continued to monitor Mr Jarvis over the next 15 minutes, but there was no change or improvement (which the nurses said they would normally see in someone who had taken NPS). They asked for an ambulance and Mr Jarvis became agitated at times while they waited.
46. The control room called an ambulance at 3.29pm, and it arrived at the prison gate at 4.05pm. The paramedics reached Mr Jarvis at 4.16pm and decided to take him to hospital. They left Stoke Heath at 4.42pm and reached the hospital at 5.10pm. Two officers escorted Mr Jarvis, who was handcuffed to an officer. Mr Jarvis was unsettled on the journey and "lashed out" with his arms from time to time but did not seem to be aware of what he was doing.
47. A short time later Mr Jarvis was put into a side room within the Accident and Emergency Department. Mr Jarvis was erratic at times and kicked out his legs and threw his arms around. Mr Jarvis had his eyes open but did not seem to recognise the officers were there and did not respond when they spoke to him. One officer described Mr Jarvis as being in a "trance", but then suddenly violent. At times the officers had to hold Mr Jarvis to prevent him hurting himself or them. He did not seem to have any control over his actions.
48. At 9.15pm, two other officers took over the bedwatch. An officer said that as they walked into the room, the other two officers were holding Mr Jarvis on the bed because he was shaking violently, moving around and making strange noises.

An officer described the noise as a snoring and snorting kind of noise and said every NPS user he had been on escort with made a similar sound. Mr Jarvis' behaviour continued to be erratic and both two officers had to physically hold Mr Jarvis at times because he was moving his arms and in danger of hitting himself in the face. Mr Jarvis did not speak at any time and the officers described him as "zombie like".

49. The officers did not think the hospital staff thought Mr Jarvis' condition was life-threatening and officers updated the prison from the hospital. Around midnight Mr Jarvis calmed down and lay on the bed as though sleeping, but his eyes were wide open.
50. Hospital records shared with the clinical reviewer show Mr Jarvis was given 10mg of diazepam (a sedative) at 1.10am. Around 1.30am a nurse said Mr Jarvis was going to be taken for an X-ray. Mr Jarvis became quiet and the shaking eased. Officers described Mr Jarvis as making a big snoring noise every minute or so, shaking a little bit and then calming down again. The officers thought Mr Jarvis was beginning to sleep things off. This continued for a while but shortly before 2.00am, one of the officers became concerned because Mr Jarvis had stopped snoring and he could not see his chest rising.
51. The officer immediately alerted a nurse. The handcuffs were removed and Mr Jarvis was taken to the resuscitation area of the hospital. The medical team were unable to resuscitate Mr Jarvis and he was pronounced dead at 2.35am.
52. The hospital have carried out their own review of the care given to Mr Jarvis while in hospital, which found that Mr Jarvis' care in hospital was deficient.
53. After Mr Jarvis' death a note was put into B Wing's mailbox giving the names of several prisoners who bought and sold things. Mr Jarvis was named as someone who sold his medication, tobacco and Mamba. No one we spoke to thought Mr Jarvis had been given something illicitly by anyone else.

Contact with Mr Jarvis' family

54. At 2.45am, the deputy governor spoke to a prison manager and asked for next of kin details. She tried to telephone Mr Jarvis' daughter at 3.00am to tell her what had happened. She said there was no answer during the three times she tried. West Midlands Police were asked to go to the address the prison had for Mr Jarvis' daughter, but when the police arrived they found she no longer lived there. The police identified the correct address and subsequently broke the news to Mr Jarvis' daughter. The duty governor spoke to her on the telephone during the morning of 15 December and offered to arrange a taxi to collect the family and take them to the hospital. Mr Jarvis' two daughters arrived at the hospital in the afternoon and met the duty governor, the family liaison officer and the chaplain. They offered their condolences.
55. The family liaison officer kept in regular contact with Mr Jarvis' daughters. The prison contributed towards the cost of Mr Jarvis' funeral in line with national Prison Service policy.

Support for prisoners and staff

56. While most officers said they had been offered support in coming to terms with what happened to Mr Jarvis, one officer said she had not received any support.
57. Staff put a note under each door letting other prisoners know of Mr Jarvis' death and a memorial service was held. Most prisoners we spoke to felt appropriately supported, but some said they did not feel enough had been offered.

Post-mortem report

58. A post-mortem examination was conducted and Mr Jarvis' cause of death could not be ascertained.
59. Extensive toxicology tests were carried out on blood and urine samples. Tests were also carried out on items taken from Mr Jarvis' cell, including cigarette ends and rolled cigarettes. Tests found methadone (at a low level), pregabalin (at a low level), quetiapine and mirtazapine in the blood and urine samples. Mr Jarvis was prescribed all of these drugs.
60. No known psychoactive substances were detected in blood or urine samples. However, traces of a psychoactive substance were found in some of the items tested in Mr Jarvis' cell. The toxicologist commented that psychoactive substances are extensively metabolised in the body and therefore the original substance is rarely detectable or detected at very low concentrations.

Findings

Monitoring of Mr Jarvis when he became unwell

61. Stoke Heath have a protocol guiding staff through what should happen when someone is suspected of having taken a new psychoactive substance. It does not give specific guidance as to what nurses should do to assess whether someone needs to go to hospital. A nurse said that in practice it is a nurse's decision to call an ambulance in such circumstances. She said that when she was first called out to Mr Jarvis, she was worried that he might vomit and choke, but did not think he needed to go to hospital. She said she asked officers to check Mr Jarvis every 15 minutes and to call her back if he was sick again or if he seemed to have deteriorated. At the second call out she said she had not seen someone "as bad" as him after taking NPS, so asked for an ambulance after monitoring him.
62. Neither the duty manager nor an officer remembered being told explicitly that observations should take place every 15 minutes. The officer thought staff were told to check Mr Jarvis in 20 minutes to half an hour, but it was unclear whose responsibility that was or where the check should be recorded. No checks were made by any of the staff working on B Wing. It was a prisoner who alerted staff that Mr Jarvis' condition had deteriorated.
63. Nurse call-outs for suspected NPS use are not an uncommon occurrence in prisons. The Head of Security thought there were around five nurse call-outs in the month prior to Mr Jarvis' death for suspected NPS use. A clear system of communicating the frequency of follow up staff checks, who will make those checks and where they will be recorded should be developed by Stoke Heath. There should be guidance about when a nurse needs to be called back.

The Governor and Head of Healthcare should ensure that when a prisoner is suspected of having taken a psychoactive substance or other drug there is clear communication between healthcare and officers about follow up monitoring, checking and recording of the prisoners' well being.

Managing the misuse of drugs and prescribed medication

64. We are concerned about the prevalence of new psychoactive substances in prisons and the effect it has on the behaviours and health of those taking it. Although not confirmed by toxicology tests, it is highly likely that Mr Jarvis smoked a new psychoactive substance shortly before becoming unwell. There were traces of such drugs found in Mr Jarvis' cell.
65. The Head of Security spoke to us about the proactive strategy Stoke Heath have in place to both reduce the supply of and demand for drugs. He thought post was the most common way for drugs to get into Stoke Heath, so all mail is screened by a drug dog. He said the prison's MDT rate was low – 2.8% of prisoners tested positive for drugs, against a target of 7%. Several prisoners we spoke to said it is still easy to get drugs in Stoke Heath. Prisoners told us that people smoke NPS because there is nothing to do and drugs help escape the boredom. A prisoner told us he thought Mr Jarvis smoked Mamba regularly, but Mr Jarvis told other prisoners that he never touched it.

66. Mr Jarvis was prescribed, among other drugs, mirtazapine (a monthly prescription in possession) and quetiapine (a weekly prescription in possession). A prisoner on Mr Jarvis' wing said there was "quite a trade" in prescribed medication, and commented that some people have quite strong medication. He thought Mr Jarvis stored some of his medication to sell to others, which funded his NPS use. Security information submitted (after Mr Jarvis' death) suggested he sold some of his medication on the wing.
67. Though we think Stoke Heath have good measures in place to reduce the availability of drugs, we recommend:

The Governor should review the drug reduction strategy to help reduce further the supply of and demand for new psychoactive substances, to ensure that staff are vigilant to signs of its use, and to emphasise the risks from the trade of prescribed medication.

Family liaison

68. There was a delay in notifying Mr Jarvis' daughter of his death. In part this was because, after not being able to reach her on the telephone in the early hours of the morning, Stoke Heath asked the police to break the news. The address Stoke Heath had was not up to date. Some prisoners at Stoke Heath are serving long sentences. Keeping next of kin information up to date is important, as relationships often change over time and people move house. There should be annual requests for prisoners to provide updates or confirmation that nothing has changed.

The Governor should ensure that annual updates of next of kin details including name, telephone numbers and addresses are requested from prisoners and noted in their NOMIS prison record.

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