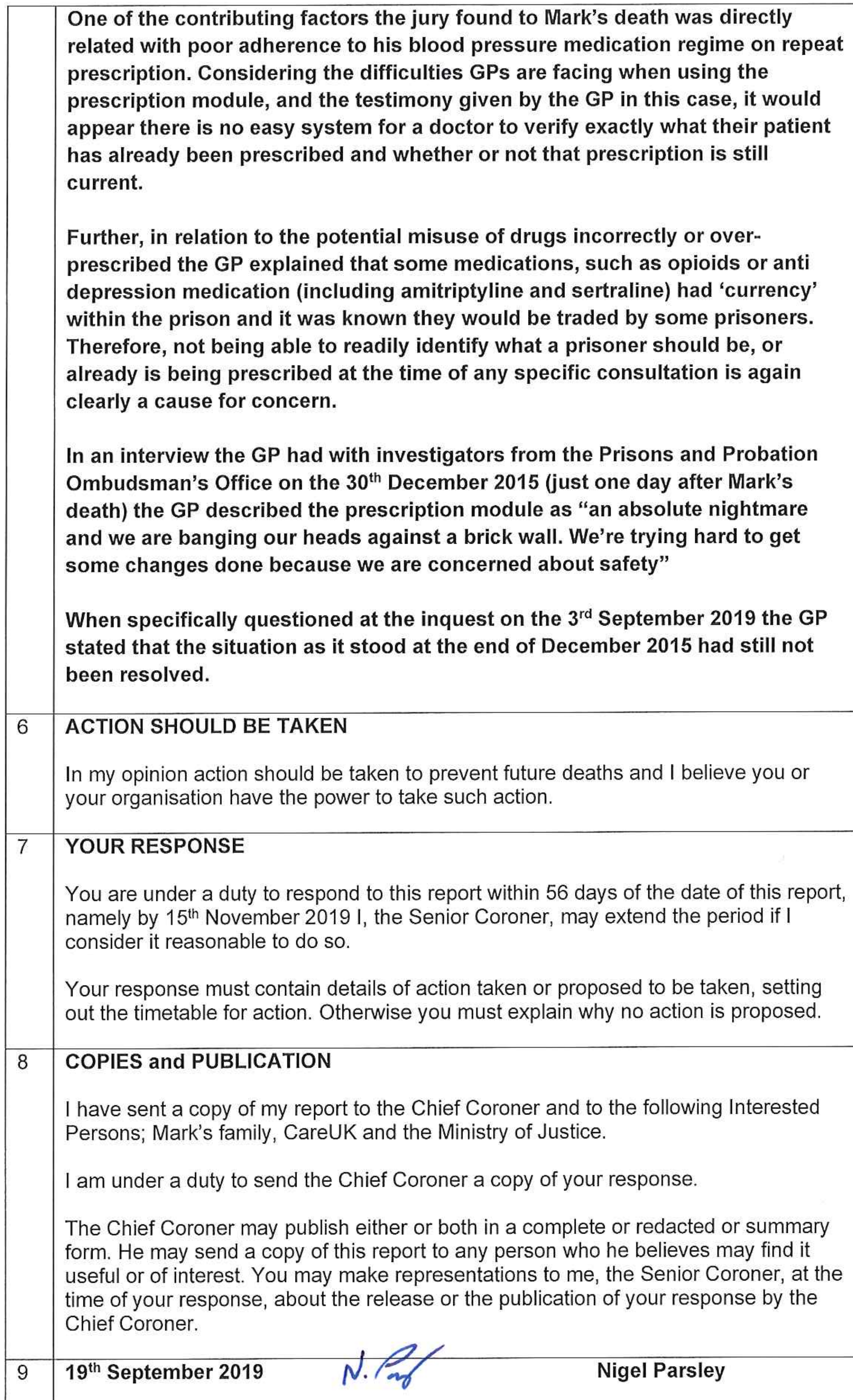
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **SystemOne TPP Ltd** **Legal Team** **TPP House** **129 Low Lane** **Horsforth** **Leeds** **LS18 5PX** **NHS England** **Legal Team** **4W08 4th Floor** **Quarry House** **Leeds** **LS2 7UE**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 30th December 2015 I commenced an investigation into the death of Mark Jarvis The investigation concluded at the end of the inquest on 4th September 2019. The conclusion of the inquest was that the death was the result of:- **A cardiac event precipitated by the ingestion of a New Psychoactive Substance.** The medical cause of death was confirmed as: **1(a) Ischaemic Heart Disease**
4	**CIRCUMSTANCES OF THE DEATH** **Mark Jarvis was found apparently deceased in his cell on Oak Wing at HMP Warren Hill, Hollesley,Suffolk at 1107hrs on Wednesday 30th December 2015 and was pronounced dead by medical staff at 1136hrs the same day.** **HMP Warren Hill at Hollesley is a medium secure prison that holds nearly 250 adult men.** **Police attended the prison shortly after the death was pronounced and were able to carry out a full investigation.** **During the course of this investigation it became apparent that the prison was responding to intelligence concerning New Psychoactive Substances (a synthetic cannabinoid called 'Spice') being available on the wing.**

	It was established that Mr Jarvis had several medical issues and was using prescribed medicines for these. **Following a post-mortem examination it was found that in addition to a heart condition that could account for his death, a New Psychoactive Substances or Spice was also found in his system.** **Also in his system were amitriptyline and sertraline, neither of which had been prescribed to him by the prison doctor.** **The jury's findings of fact identified the following as a contributory factors to Mark's death:-** **Other causes materially contributing to the death of Mark Jarvis are:-** **a) Lifestyle - smoking** **- abuse of non-prescribed medication e.g. amitriptyline, sertraline.** **b) Historic lack of monitoring and management of hypertension.** **c) Use of synthetic cannaboids.**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows. – **1. During the course of the inquest a GP who was responsible for medical care at HMP Warren Hill gave evidence in relation to the computer system, SytmnOne which was used to review and prescribed medicines to the prisoners at the time of Mark's death.** **The court was told that the SystmOne online prescription 'module' was not clear to read or easy to understand and appeared incompatible with the prison's own IT system.** **The GP described that this left them in the situation of not being sure what a patient had been previously prescribed, not being sure what repeat prescriptions were in place and that they had no way of readily understanding what had been taken by a particular patient or when they were supposed to have taken it.** **It was also explained that there was no direct link on the system between medications prescribed and previous diagnoses. Due to the time it took to navigate the records it was reported that some GP's used their experience to identify a previous diagnosis from the repeat prescriptions recorded in the prescription module.** **The GP further described that removing a prisoner's prescription from the system when it was no longer necessary was very difficult.**



One of the contributing factors the jury found to Mark's death was directly related with poor adherence to his blood pressure medication regime on repeat prescription. Considering the difficulties GPs are facing when using the prescription module, and the testimony given by the GP in this case, it would appear there is no easy system for a doctor to verify exactly what their patient has already been prescribed and whether or not that prescription is still current.

Further, in relation to the potential misuse of drugs incorrectly or over-prescribed the GP explained that some medications, such as opioids or anti depression medication (including amitriptyline and sertraline) had 'currency' within the prison and it was known they would be traded by some prisoners. Therefore, not being able to readily identify what a prisoner should be, or already is being prescribed at the time of any specific consultation is again clearly a cause for concern.

In an interview the GP had with investigators from the Prisons and Probation Ombudsman's Office on the 30th December 2015 (just one day after Mark's death) the GP described the prescription module as "an absolute nightmare and we are banging our heads against a brick wall. We're trying hard to get some changes done because we are concerned about safety"

When specifically questioned at the inquest on the 3rd September 2019 the GP stated that the situation as it stood at the end of December 2015 had still not been resolved.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you or your organisation have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th November 2019 I, the Senior Coroner, may extend the period if I consider it reasonable to do so.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; Mark's family, CareUK and the Ministry of Justice.

I am under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9 19th September 2019 N. P [signature] **Nigel Parsley**