

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John O'Meara a prisoner at HMP Wormwood Scrubs on 29 March 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.

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 O'Meara died on 29 March 2016 of methadone toxicity at HMP Wormwood Scrubs. He was 50 years old. I offer my condolences to Mr O'Meara's family and friends.

I am satisfied that healthcare staff at Wormwood Scrubs treated Mr O'Meara's drug and alcohol withdrawal appropriately. They moved him to a specialist unit and followed a methadone stabilisation care plan. I agree with the clinical reviewer that the care that he received was equivalent to that he could have expected to receive in the community.

However, given the possibility that Mr O'Meara took illicit drugs in prison which may have contributed to his death, I echo HM Inspectorate of Prisons' call for Wormwood Scrubs to devise a drug reduction policy and address the diversion of medication.

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

October 2016

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Summary

Events

1. On 26 March 2016, Mr John O'Meara was sentenced to 12 weeks in prison for theft and he was sent to HMP Wormwood Scrubs. This was not his first time in prison.
2. When he arrived at the prison, Mr O'Meara told a nurse he was withdrawing from drugs and alcohol, which included crack, cocaine and heroin. The nurse noted that he appeared 'sleepy'. A drug test revealed that Mr O'Meara had tested positive for opiates, benzodiazepine and cocaine.
3. Later that day, a doctor saw Mr O'Meara, who confirmed that he smoked £40 of heroin and £100 of crack each day. The doctor diagnosed alcohol and opiate dependence and referred Mr O'Meara to the prison's Conibeere Stabilisation Unit for a methadone stabilisation and alcohol detoxification programme. He also prescribed a number of medications to treat the symptoms of withdrawal, including a 10mls dose of methadone.
4. On 27 March, a nurse gave Mr O'Meara two 10mls doses of methadone, one in the morning and one in the afternoon.
5. On 28 March, a nurse completed a substance misuse nursing assessment and created a methadone stabilisation care plan to help Mr O'Meara withdraw from drugs and alcohol as safely as possible. Healthcare staff also gave him two doses of methadone, 20mls in the morning and 10mls in the afternoon.
6. On the morning of 29 March, a nurse gave Mr O'Meara a 20mls dose of methadone and other withdrawal medication. On the same day, a health and wellbeing practitioner and a prison officer both saw Mr O'Meara and noted that he looked sweaty and drowsy, but considered this was because he was withdrawing.
7. At approximately 2.21pm on 29 March, a prison officer unlocked Mr O'Meara's cell for association but he did not respond. The officer entered his cell and saw that his arm and face were blue. The officer called for assistance and other officers were quickly there. The officer then called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) and the communications room called an ambulance immediately.
8. Several healthcare staff responded and started cardiopulmonary resuscitation (CPR). They also fitted a device to open up Mr O'Meara's airway, gave him oxygen and attached the defibrillator, which advised that there was no shockable rhythm. Paramedics arrived at 2.35pm and took over the CPR. They also gave Mr O'Meara adrenalin, naloxone (to treat a potential drug overdose), and fitted an automated CPR device. An ultrasound showed no movement in Mr O'Meara's heart wall or valves, so paramedics stopped CPR and declared Mr O'Meara's death at 3.17pm.

Findings

9. We agree with the clinical reviewer that Mr O'Meara's care in prison was equivalent to that he could have expected to receive in the community. Staff identified that he was dependent on drugs and alcohol and appropriately referred him to the stabilisation unit. Appropriate plans were implemented to ensure his safe withdrawal from drugs and alcohol. The clinical reviewer confirmed that Mr O'Meara's methadone and alcohol withdrawal drug dosages were appropriate and in line with guidance from the British National Formulary.
10. The post-mortem and toxicology examination revealed Mr O'Meara died from methadone toxicity. Three non-prescribed drugs were also found in Mr O'Meara's blood and urine. We cannot rule out the possibility that Mr O'Meara may have obtained other drugs illicitly in prison including additional methadone, which taken alongside his prescribed dose proved lethal.
11. We note that in their most recent inspection report HM Inspectorate of Prisons were concerned that Wormwood Scrubs did not have a drug reduction policy and that there were issues of diverting medication. We do not make a recommendation in this area in relation to Mr O'Meara's death – to do so would be speculative - but we note that the prison have committed to responding to a recommendation from the Inspectorate by October 2016.
12. When the officer found Mr O'Meara unresponsive in his cell she should have called an emergency code before calling her colleagues. However, we are satisfied that the very short delay did not affect the outcome for Mr O'Meara.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator visited Wormwood Scrubs. He obtained copies of relevant extracts from Mr O'Meara's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr O'Meara's clinical care at the prison.
16. The investigator and the clinical reviewer interviewed four members of staff at Wormwood Scrubs on 12 May 2016. The investigator also interviewed two members of staff at Wormwood Scrubs on 13 May.
17. Another investigator interviewed one member of staff by telephone on 2 June.
18. We informed HM Coroner for HM Coroner Western London District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr O'Meara's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr O'Meara's son had the following questions:
 - How was Mr O'Meara assessed when he arrived at the prison?
 - How did Mr O'Meara present on 29 March and what did staff do about it?
 - What medication did Mr O'Meara receive in prison?
 - He also asked for details of the emergency response.
20. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.
21. Mr O'Meara's family received a copy of the initial report. The solicitor representing Mr O'Meara's 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 Wormwood Scrubs

22. HMP Wormwood Scrubs is a large local prison in West London, holding over 1,200 men, either convicted or remanded by courts in the local area. It is also a designated resettlement prison for London prisoners. At the time of Mr O'Meara's death, Central London Community Healthcare provided healthcare services. There is 24-hour healthcare cover and an inpatient unit with 17 beds.

HM Inspectorate of Prisons

23. The most recent inspection of Wormwood Scrubs was in December 2015. Inspectors had a number of concerns about the prison, which included that a large number of prisoners often arrived at the prison late in the day, which undermined the ability of reception and health staff to identify risks and needs. On occasions, this resulted in prisoners missing their initial health screening and made detoxification arrangements unsafe, especially for those prisoners suffering with alcohol withdrawal.
24. While inspectors had concerns about the prison, they found that the quality of health services was reasonable with an adequate range of primary care services. Inspectors found that standardised, regularly checked emergency bags, including oxygen and automated external defibrillators, were located in clinical rooms across the prison. They found that most prison staff were aware of the emergency response protocol but too few had received emergency first-aid training.
25. Inspectors found that drugs and alcohol were easily available but there was no supply reduction strategy or action plan. A survey of prisoners found that 39% said that it was easy to get drugs and 11% said that they had developed a problem with diverted medication since they had been at the prison. Inspectors found that these results were all higher than at similar prisons and than at the time of the previous inspection. The daily administration of controlled drugs was not managed well, as they saw prisoners jostling around the medication hatch, with little challenge by officers. This meant that the process was open to abuse.
26. In response to a recommendation contained in the most recent inspection report about reducing the availability and use of drugs, Wormwood Scrubs planned on introducing a drug supply and reduction strategy, starting monthly drug strategy committees, completing daily mandatory drug tests and introducing a new drug strategy policy. The prison committed to taking these steps by October 2016.
27. In response to a recommendation about prison staff adequately supervising the administration of medicines, the prison confirmed that wing managers would ensure that prison staff observed the medication queues. The prison introduced this step in July 2016.

Independent Monitoring Board

28. 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 2015, the IMB noted that healthcare services had received a commendable inspection report from the Care Quality Commission.

Previous deaths at HMP Wormwood Scrubs

29. Mr O'Meara was the fifth prisoner to die at HMP Wormwood Scrubs since January 2015. There have been three further deaths since. There are no significant similarities between Mr O'Meara's death and these other deaths at the prison.

Key Events

30. On 26 March 2016, Mr John O'Meara was sentenced to 12 weeks in prison for theft and he was sent to HMP Wormwood Scrubs. This was not his first time in prison.
31. Mr O'Meara arrived at the prison at 6.15pm and a nurse carried out a comprehensive initial health screen. Mr O'Meara said that he was withdrawing from drugs and alcohol and regularly used crack cocaine, cannabis and heroin. He also said he drank one and a half bottles of vodka a day. Mr O'Meara said that he suffered from chest pains at times. She checked Mr O'Meara's blood pressure, which was 128/76 (within the normal range), and noted that he appeared 'sleepy'.
32. At 8.47pm, a nurse practitioner performed a drug test, which revealed that Mr O'Meara had tested positive for opiates, benzodiazepine (a sedative often taken illicitly) and cocaine.
33. At 9.27pm, a prison GP met Mr O'Meara, who confirmed that he smoked £40 worth of heroin and £100 worth of crack each day. The GP examined Mr O'Meara and found that he was alert and lucid, but had a tremor in his outstretched hands. The doctor diagnosed alcohol dependence syndrome and drug dependence and referred Mr O'Meara to the prison's Conibeere Stabilisation Unit for a methadone stabilisation and alcohol detoxification programme. He also prescribed a number of medications, including chlordiazepoxide (to treat alcohol withdrawal), methadone (to treat morphine and heroin addiction) and loperamide, mebeverine, metoclopramide, thiamine and vitamin B (all to help treat the symptoms of withdrawal).
34. At 9.56pm, a nurse practitioner gave Mr O'Meara his first 10mls dose of methadone and at 11.09pm he moved to the Conibeere Unit.
35. On 27 March, a nurse gave Mr O'Meara two 10mls doses of methadone (the lowest dose recommended by the British National Formulary); one in the morning and one in the afternoon. While giving him his methadone, the nurse checked Mr O'Meara's blood pressure, which was 125/79 in the morning and 118/75 in the afternoon (both normal); and his heart rate, which was 55 beats per minute (bpm) in the morning (low) and 64 bpm in the afternoon (normal). The nurse found that Mr O'Meara was responding well to his drug and alcohol withdrawal treatment, though a substance misuse nursing assessment was still outstanding.
36. On 28 March, a nurse completed the substance misuse nursing assessment. As part of the assessment, the nurse completed a methadone stabilisation care plan and an alcohol detoxification care plan to help Mr O'Meara withdraw as safely as possible. He also checked Mr O'Meara's blood pressure, which was 124/79 (normal), and his heart rate, which was 51 bpm (low).
37. Following the substance misuse assessment, a nurse gave Mr O'Meara a 20mls dose of methadone, which was an increase in line with the stabilisation care plan.

38. Later that day, the nurse checked Mr O'Meara's blood pressure, which was 133/74 (normal) and his heart rate, which was 80 bpm (normal). She also gave him a 10mls dose of methadone in line with the stabilisation plan.

29 March 2016

39. At 8.47am, a nurse gave Mr O'Meara a 20mls dose of methadone and his chlordiazepoxide medication.
40. Between 9.30am and 10.30am, a health and wellbeing practitioner completed a RAPt (The Rehabilitation of Addicted Prisoners Trust) Substance Misuse Assessment with Mr O'Meara. The assessment took place through the hatch of his cell door and she said that Mr O'Meara looked quite sweaty, though this was normal for people withdrawing from alcohol.
41. During the assessment, they discussed Mr O'Meara's substance misuse and the health and wellbeing practitioner created an initial care plan, where the local drug and alcohol support team would be told about his substance misuse.
42. At approximately 12.00pm, an officer visited Mr O'Meara's cell because the prisoners who hand out the lunch packs had been unable to get a response from him. When she entered his cell, Mr O'Meara was asleep so she shook him to wake him up. Mr O'Meara woke up and turned to face her. She thought that he looked very drowsy, but he only spoke to her to acknowledge that his food had arrived. He then turned and fell asleep again so she left his cell.
43. The officer told us she was not concerned with Mr O'Meara being drowsy because his chlordiazepoxide medication caused drowsiness and he had responded to her.
44. At approximately 2.21pm, an officer unlocked Mr O'Meara's cell and called out "association" (this is when prisoners can move about the wing and socialise with each other). Mr O'Meara did not respond or move, so she banged on the cell door and called out his name. Again, Mr O'Meara did not respond so she entered the cell and saw that Mr O'Meara was lying on his bed with his left arm outstretched. She saw that his arm and face were blue so she called to two officers for assistance. She told one officer to ask for healthcare staff to attend.
45. Another officer responded immediately and entered Mr O'Meara's cell. He saw that Mr O'Meara was blue so told an officer to call a code blue emergency (which indicates that a prisoner is unconscious or not breathing). The officer radioed a code blue and the communications room called an ambulance immediately.
46. Two nurses responded immediately with the emergency bag that held oxygen and a defibrillator. They moved Mr O'Meara off his bed to the floor, and started cardiopulmonary resuscitation (CPR). Other healthcare staff responded and they continued CPR. They also fitted a device to open up Mr O'Meara's airway, gave him oxygen and attached the defibrillator, which advised that there was no shockable rhythm.
47. At 2.35pm, paramedics arrived and took over the CPR, they also gave Mr O'Meara five doses of adrenalin and one dose of naloxone (to treat a potential drug overdose), and fitted an automated CPR device. They performed an

ultrasound scan, which showed no movement in Mr O'Meara's heart wall or valves. As a result, the paramedics stopped CPR and declared Mr O'Meara's death at 3.17pm.

Contact with Mr O'Meara's family

48. Following Mr O'Meara's death, the prison appointed two prison managers as family liaison officers. Mr O'Meara had not provided any details for his next of kin so one manager contacted his solicitor and offender manager but they were unable to assist. She then reviewed the records from his previous sentences and located an address for Mr O'Meara's sisters.
49. At 7.25pm on 29 March, both prison managers visited Mr O'Meara's sisters to inform them of his death and to offer their condolences and support. Mr O'Meara's sisters said that they would inform his sons of his death.
50. On 7 April, one of Mr O'Meara's sons contacted the prison and one prison manager spoke to him about his father and offered condolences and support. She remained in contact with him.
51. Mr O'Meara's funeral was on 22 April. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

52. After Mr O'Meara's death, a senior prison manager 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.
53. The prison posted notices informing staff and prisoners of Mr O'Meara's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm prevention in case they had been adversely affected by Mr O'Meara's death. Listeners (prisoners trained by Samaritans to provide confidential support to other prisoners) also visited the Conibeere Unit to provide support.

Post-mortem report

54. A post-mortem and toxicology examination found that Mr O'Meara died from methadone toxicity. The major toxic effect of opiate drugs is their depressive effect on the central nervous system. The post-mortem also found the presence of carbamazepine, diazepam and dihydrocodeine, which had not been prescribed to Mr O'Meara.

Findings

Substance misuse

55. When Mr O'Meara arrived at Wormwood Scrubs, healthcare staff correctly identified that he was dependent on drugs and alcohol. Healthcare staff quickly moved Mr O'Meara to the Conibeere Stabilisation Unit for a methadone stabilisation and alcohol detoxification regime, which a nurse created on the morning of 28 March.
56. The clinical reviewer confirmed that the dosage of methadone that healthcare staff prescribed and administered to Mr O'Meara was at a low level and was in line with guidance from the British National Formulary about prescribing to individuals with low tolerance of methadone. The clinical reviewer also confirmed that the alcohol withdrawal drugs prescribed to Mr O'Meara were routinely used and were at standard dosages.
57. We agree with the clinical reviewer that the care that Mr O'Meara received at Wormwood Scrubs was equivalent to that he could have expected to receive in the community.
58. The post-mortem examination revealed three non-prescribed drugs in Mr O'Meara's blood and urine. We cannot rule out that he may have obtained these and other drugs, including methadone, while in prison, resulting in him taking a lethal level of the drug.

Drug reduction policy

59. During their recent inspection, HM Inspectorate of Prisons noted that Wormwood Scrubs did not have a drug supply reduction plan, which had led to higher than normal responses from prisoners that drugs and diverted medication were easily available.
60. The presence of three non-prescribed drugs in Mr O'Meara's blood and urine suggests that the issue of illicit drugs remains significant at the prison. However, we do not make a recommendation in this area because we are conscious that Wormwood Scrubs have committed to reducing the availability of drugs and to better supervising the administration of medication, in light of recommendations from the Inspectorate.

Emergency response

61. When the officer found Mr O'Meara unresponsive in his cell, she called for assistance from colleagues rather than a code blue emergency (indicating a prisoner is unresponsive or not breathing). The reason for calling an emergency code is to ensure an ambulance is called immediately and healthcare staff bring the appropriate equipment. However, her colleagues responded quickly and she then called a code blue very shortly afterwards, an ambulance was called and healthcare staff brought the correct equipment. As a result, we are satisfied that the small delay did not have any significant impact in the outcome for Mr O'Meara.

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