Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Williams, a prisoner at HMP Wormwood Scrubs, on 29 December 2018

A report by the Prisons and Probation Ombudsman

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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*

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 William Williams died of the respiratory depressive effect of methadone, exacerbated by the concurrent use of pregabalin on 29 December 2018, at HMP Wormwood Scrubs. Mr Williams was 52 years old. I offer my condolences to his family and friends.

Mr Williams was remanded to Wormwood Scrubs on 24 December. He had a long history of substance misuse and told healthcare staff that he had been taking a complex and unconventional mix of prescription medications in the community, including methadone (used as a heroin substitute in the treatment of addiction). He also said he had been using heroin in the community.

Healthcare staff could not obtain his community medical records because of the Christmas holiday. He was placed on a detoxification programme involving a gradually increasing dose of methadone. On the day before his death, he was also prescribed pregabalin and diazepam, as well as methadone.

These are all drugs that can affect breathing. I am concerned that despite this, Mr Williams' clinical signs were not monitored regularly as they should have been and were not monitored at all on the day of his death. The combined effects of the drugs caused his death.

I agree with the clinical reviewer that the clinical care Mr Williams received at Wormwood Scrubs was not equivalent to that which 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.

Sue McAllister CB
Prisons and Probation Ombudsman **May 2020**

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Summary

Events

1. Mr William Williams was remanded to HMP Wormwood Scrubs on 24 December 2018, for breaching a restraining order.

2. He had a long history of substance misuse and had twice completed successful detoxification programmes in prison earlier in 2018 at HMP Bedford and HMP Peterborough.

3. When Mr Williams arrived at Wormwood Scrubs, he said he had been using £30 of heroin a day in the community and that he had been receiving a complex mix of prescription medications (including methadone, an opioid substitute used in the treatment of heroin addiction). His community medical records could not be obtained because of the Christmas holiday. A prison GP prescribed medication for opiate withdrawal and placed him on a methadone detoxification programme.

4. Between 25 and 27 December, a prison nurse assessed Mr Williams. He showed no signs of opiate withdrawal. His methadone dose was increased in line with his prescription.

5. On 28 December, Mr Williams told a prison GP that he felt sick and sweaty. He said that this was due to him not receiving some of the medication he had been prescribed in the community. Healthcare staff were still waiting for Mr Williams' GP community records.

6. The GP noted that Mr Williams said he had been prescribed pregabalin and diazepam in the community and restarted them at a lower dose, in addition to the methadone he was already receiving. The GP stopped his prescription of dihydrocodeine (another opiate).

7. The GP made a note in Mr Williams' medical records for his clinical observations to be monitored and for him to be monitored for drowsiness and have an ECG. There is no evidence that staff completed an ECG.

8. On 29 December, Mr Williams was given his prescribed medication at about 10.00am and 3.30pm, but his clinical observations were not taken.

9. At around 5.45pm that evening, Mr Williams' cellmate rang the emergency cell bell because he was concerned about Mr Williams. When an officer attended, he found Mr Williams unresponsive. The officer asked a nurse who was nearby for assistance. The nurse started CPR. The officer called a code blue emergency over the radio and an ambulance was called immediately. More staff arrived and continued with CPR until the paramedics arrived at 5.55pm.

10. The paramedics were unable to resuscitate Mr Williams and at 6.45pm, they confirmed that Mr Williams had died.

11. The post-mortem report found that Mr Williams' cause of death was the respiratory depressive effect of methadone, exacerbated by the concurrent use of pregabalin.

Findings

12. Healthcare staff at HMP Bedford and HMP Peterborough failed to share Mr Williams' prison medical records with his community GP when he was released from prison sentences earlier in 2018. As a result, the community GP re-prescribed methadone and other medications despite Mr Williams having completed a detoxification programme successfully in prison on both occasions. This meant that he was prescribed drugs he did not need and that his drug-seeking behaviour was not identified.

13. The clinical reviewer concluded that the healthcare Mr Williams received at Wormwood Scrubs was not equivalent to that which he could have expected to receive in the community. She said that, although Mr Williams would have been a management challenge for healthcare in any setting, there were a number of errors and missed opportunities.

14. In the absence of Mr Williams' community GP records, healthcare staff accepted Mr Williams' account that he had been using heroin in the community. As a result, Mr Williams was placed on a drug detoxification programme, involving a gradually increasing dose of methadone, which he may not have needed.

15. When he reported feeling unwell, it was assumed that this was the result of opiate withdrawal, although it may not have been.

16. He was prescribed pregabalin and diazepam, in addition to the methadone (all drugs that can affect breathing). This was a potentially dangerous combination. His clinical observations should have been taken regularly and he should have been checked for signs of drowsiness, but this did not happen. Staff also failed to complete an ECG.

17. The clinical reviewer found that the combined effects of the drugs Mr Williams was prescribed caused his death.

Recommendations

- The Heads of Healthcare at HMP Bedford and HMP Peterborough should ensure that prisoners' prison medical records are shared with the community GP on release.

- The Head of Healthcare and the lead clinician for substance misuse at HMP Wormwood Scrubs should review the way in which urine drug screening tests are used and the results are reviewed to ensure that, before methadone detoxification is initiated, the results are considered in addition to all the available clinical information to establish if any other substances have been taken by the prisoner which could produce a positive opiate response.

- The Head of Healthcare and the lead GP at Wormwood Scrubs should meet the two GPs involved in this case and review the clinical care provided to Mr Williams with them in a structured way.

- The Head of Healthcare at Wormwood Scrubs should ensure that all prescribers of medication consider the effects of prescribing multiple medications which affect breathing, to ensure that:

- there is a clear risk/benefit analysis; and
- there is appropriate clinical oversight and that vital sign observations are carried out as required.

The Investigation Process

18. 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 her. No one responded.

19. The investigator obtained copies of relevant extracts from Mr Williams' prison and medical records.

20. The investigator interviewed nine members of staff at Wormwood Scrubs on 10 and 24 April 2019.

21. NHS England commissioned an independent clinical reviewer to review Mr Williams' clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

22. We informed HM Coroner for London of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

23. We wrote to Mr Williams' sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Williams's sister raised some issues about the release of Mr Williams' body following his death and the coronial service which are outside the PPO's remit, and we advised her to contact the coroner's office.

24. Our investigation was suspended between 4 January and 23 August 2019 while we waited for the cause of death and toxicology reports. The completion of this report was delayed as a result.

25. Mr Williams' family received a copy of the draft report. They did not make any comments.

26. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out no factual inaccuracies.

Background Information

HMP Wormwood Scrubs

27. HMP Wormwood Scrubs is a local prison in West London, holding nearly 1,300 prisoners on remand from West London courts and prisoners from London serving short sentences or nearing the end of long sentences. Care UK provides primary physical care, as well as mental health care and substance misuse services.

28. In August 2018, Wormwood Scrubs was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

29. The most recent inspection of HMP Wormwood Scrubs was in September/October 2019. Inspectors found that there had been much positive progress since the previous inspection in July 2017 when they had described the prison as being in a state of crisis. They said, however, that while the progress made had been impressive, it was still fragile.

30. The inspectors found that health services were generally good. All new arrivals had an initial health screen and individuals with substance use problems, or experiencing acute withdrawal, had immediate access to specialist medical support that enabled prompt initiation of treatment. First night support for patients detoxing from drugs or alcohol had improved and was now thorough, with patients placed on the Conibeere unit to closely monitor their health and continue stabilisation. Clinical substance misuse treatment was sound and offered safe, clinically responsive care.

Independent Monitoring Board

31. 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 May 2018, the IMB reported that until July 2017, staff shortages meant that many daily routines could only function by diverting staff from other tasks. However, they noted that by January 2018, the staffing situation had begun to improve as new staff were recruited. They found that the standard of healthcare remained generally acceptable but there were problems getting prisoners to appointments. They noted that Wormwood Scrubs did not always provide the same level of access to healthcare that would be available in the community.

Previous deaths at HMP Wormwood Scrubs

32. Mr Williams was the sixth prisoner to die at Wormwood Scrubs since January 2017. One of the previous deaths was from natural causes, one was a homicide and four were self-inflicted. There were no significant similarities with the

previous deaths. Since Mr Williams' death, there has been a further self-inflicted death and two deaths from natural causes.

Key Events

33. On 24 December 2018, Mr William Williams breached the conditions of his restraining order and was remanded to HMP Wormwood Scrubs. Mr Williams had a long history of alcohol and substance misuse, which included benzodiazepines (sedatives), heroin and cocaine.

HMP Bedford (May 2018) and HMP Peterborough (September/October 2018)

34. Mr Williams had served previous sentences at Bedford and Peterborough during 2018. On each occasion, his community GP told prison healthcare staff at about his prescribed medications. These included amitriptyline (an antidepressant), aspirin, diazepam (also known as Valium, a type of benzodiazepine), dihydrocodeine (an opioid painkiller) and pregabalin (used for nerve pain, epilepsy and anxiety). Following healthcare reviews at both prisons, healthcare staff reduced his medications. He was placed on methadone and benzodiazepine detoxification programmes and was monitored for withdrawal symptoms. His pregabalin prescription was also stopped.

35. Mr Williams successfully completed the detoxification programmes at both prisons and at the point of his release, he was only being prescribed aspirin at Bedford and aspirin and amitriptyline at Peterborough.

36. However, healthcare staff at Bedford failed to share this information with his community GP, and it appears that Peterborough also failed to share it. As a result, following his release from Bedford (in May) and Peterborough (in October), Mr Williams' community GP re-prescribed him the full list of medications he had received before being sent to prison.

HMP Wormwood Scrubs

37. On 24 December, Mr Williams was sent to HMP Wormwood Scrubs. A nurse completed his reception screening. She noted that he had injuries to his left side and shoulder from a car accident in 2002 which had left him with chronic pain, and that he was blind in his left eye. Mr Williams said that he had bipolar affective disorder – although healthcare staff found no evidence of this in his medical records - and that he took diazepam for this,

38. Mr Williams provided healthcare staff with a list of the medications he said he was prescribed in the community, including amitriptyline, aspirin, diazepam, dihydrocodeine and pregabalin. He also said that he had been taking £30 worth of heroin daily. A urine sample tested positive for benzodiazepines, opiates, cocaine and buprenorphine (also known as Subutex and used as a substitute for heroin in the treatment of addiction). It was negative for methadone, cannabis and amphetamine.

39. Mr Williams saw a prison GP later that day. The GP could not check Mr Williams' community medical records because of the Christmas holiday, so he had no access to his prescribing history. The GP prescribed amitriptyline (150mg daily), aspirin, (75mg daily), diazepam (50mg daily), dihydrocodeine (240mg daily). He did not prescribe Mr Williams diazepam or pregabalin but

prescribed ibuprofen, loperamide, mebeverine, metoclopramide and naloxone 'as required' for relief from opioid withdrawal symptoms.

40. The GP placed Mr Williams on a variable dose of methadone, and he was then transferred to the prison's Conibeere Unit for opiate detoxification and a methadone titration regime (gradual increases on a daily basis to achieve the right dose).

41. At 11.30am, on 25 December, a nurse completed Mr Williams' second medical screening. She completed an assessment and created a care plan. Mr Williams was not showing any signs of opiate withdrawal.

42. On 26 December, Mr Williams received 15mg of methadone at 9.10am and 10mg at 3.59pm. He also received 150mg of amitriptyline. There are no clinical entries or physical observations recorded in his medical record.

43. At 9.20am on 27 December, a nurse assessed Mr Williams but he showed no signs of opiate withdrawal. His methadone dose was increased to 25mg and he was given 150mg of amitriptyline.

44. On 28 December, at a multidisciplinary meeting, Mr Williams told a prison GP that he felt sick and sweaty. He said this was due to not receiving the medication he had been prescribed in the community. The prison was still waiting for the GP community records, despite 27 and 28 December being working days.

45. Mr Williams' medication was reconciled by the pharmacy technician and sent to a prison GP for review. The GP noted that had not been receiving diazepam and he added this to Mr Williams' prescription at a lower dose of 30mg a day, with a plan for reducing it further. He also noted that Mr Williams had not been receiving pregabalin and added this. The GP also noted that Mr Williams was being co-prescribed dihydrocodeine and methadone (both opiates), and he asked a nurse to speak with Mr Williams to give him a choice of which opiate medication he would prefer to take. Mr Williams told the nurse that he wanted to continue with methadone and the dihydrocodeine was stopped.

46. The GP made a note in Mr Williams' medical record that healthcare staff should monitor his respiratory rate, blood pressure, pulse and opiate withdrawal (using the Clinical Opiate Withdrawal Scale *(*COWS*)* tool) and that he should be monitored for drowsiness twice daily. He noted that methadone, diazepam, pregabalin and amitriptyline should be stopped and that staff should contact the duty doctor or emergency services if these symptoms were noted.

47. The GP also noted in Mr Williams' medical record that an ECG should be done that day. A nurse told us at interview that he did not see this request. There is no evidence in Mr Williams' medical records that an ECG was completed.

Events of 29 December

48. At 9.52am, Mr Williams was administered 35mg of methadone, 15mg of diazepam and 300mg of pregabalin. At around 3.30pm, he was given 300mg of pregabalin,150mg of amitriptyline and 15mg of diazepam. There is no evidence in Mr Williams' medical record that staff took his vital sign observations.

49. At around 5.45pm, Mr Williams' cellmate pressed the emergency cell bell. An officer responded. Mr Williams' cellmate told the officer that he was concerned about Mr Williams. The officer shouted over to a nurse, who was also on the unit, and she attended immediately. The officer and nurse entered the cell and saw Mr Williams lying on his bed but they were unable to get a response from him. The officer called a code blue emergency over the radio. The nurse began cardio-pulmonary resuscitation (CPR) on the bed and the officer moved Mr Williams' cellmate to another cell.

50. At 5.50pm, another nurse attended, followed by a prison GP and two other nurses. They continued with CPR and managed Mr Williams' CPR airway. The defibrillator was applied by a nurse but it advised that a shock was not required, so staff continued with CPR.

51. At 5.55pm, the paramedics arrived and took over Mr Williams' care. After 50 minutes of attempted resuscitation with no response, a joint decision was made to stop treatment.

52. At 6.45pm, paramedics confirmed that Mr Williams had died.

Contact with Mr Williams' family

53. At 7.00pm, a prison manager was appointed to act as the prison's family liaison officer (FLO). The FLO and an officer arrived at Mr Williams' sister's home address at 10.30pm. They informed her of Mr Williams' death and offered their support.

54. Mr Williams' funeral was held on 21 February 2019. The prison offered a financial contribution towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

55. After Mr Williams' death, a prison manager debriefed the staff who were involved in the incident giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

56. The prison posted notices informing other prisoners of Mr Williams' 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 Williams' death.

Post-mortem report

57. The post-mortem report gave Mr Williams' cause of death as the respiratory depressive effect of methadone, exacerbated by the concurrent use of pregabalin. (Respiratory depression is slow, shallow and ineffective breathing which results in too little oxygen being available to the body. Certain drugs, including methadone and pregabalin, can cause respiratory depression when taken in large or excessive doses, or when taken in combination with other drugs.)

58. The toxicology report concluded that the concentrations of methadone, 0.42mg/L, pregabalin, 11.7mg/L, and amitriptyline, 0.51mg/L, in Mr Williams' blood were higher than what would be seen in normal therapy. The blood concentration of

amitriptyline, although high, was likely to be due to chronic (long-term), rather than acute (recent) administration.

59. The report also found that the concentration of methadone in Mr Williams' body has been associated in previous cases with causing respiratory depression and death, and that any respiratory depression would have been made worse by the presence of pregabalin.

Findings

Clinical care

HMP Bedford and HMP Peterborough

60. Before arriving at Wormwood Scrubs, Mr Williams had served two separate sentences at HMP Bedford and HMP Peterborough. On both occasions prison healthcare staff carefully reviewed his complex and unconventional medication regime and made effective changes to reduce the excessive amounts of benzodiazepines and opiates he was being prescribed in the community. Mr Williams completed two detoxification programmes successfully during these sentences.

61. However, we are concerned that both prisons failed to share this information with his community GP when he was released. As a result, Mr Williams' community GP re-prescribed his original list of medications, which included medications for opiate withdrawal which he no longer needed, and his drug-seeking behaviour was not identified. We make the following recommendation:

    The Heads of Healthcare at HMP Bedford and HMP Peterborough should ensure that prisoners' prison medical records are shared with the community GP on release.

HMP Wormwood Scrubs

62. The clinical reviewer concluded that the clinical care Mr Williams received at Wormwood Scrubs was not equivalent to that which he could have expected to receive in the community.

63. She commented that this was a complex case and that the rationale for the medication being provided to Mr Williams in the community was unclear - and may not have been clear even if the GP records had been available. She also said that Mr Williams' would have been a management challenge for healthcare in any setting. However, even taking this into account, she found that there were several errors and missed opportunities by healthcare staff to manage Mr Williams' drug misuse and detoxing effectively.

64. When he arrived at Wormwood Scrubs, Mr Williams provided healthcare staff with a list of the medications he said he was being prescribed in the community. He tested positive for benzodiazepines, opiates, cocaine and buprenorphine. He also told staff that he was taking £30 worth of heroin a day in the community. The clinical reviewer is concerned that this claim should have been tested in more detail and that specific drug screening should have been undertaken to look for the presence of heroin in his urine. As a result, Mr Williams was started on a heroin detoxification programme with methadone which may not have been necessary. We recommend:

    The Head of Healthcare and the lead clinician for substance misuse at HMP Wormwood Scrubs should review the way in which urine drug screening tests are used and the results are reviewed to ensure that, before methadone detoxification is initiated, the results are considered in addition

to all the available clinical information to establish if any other substances have been taken by the prisoner which could produce a positive opiate response.

55. The clinical reviewer also noted that the drug history taken when Mr Williams arrived at Wormwood Scrubs was incomplete, even though he had been able to say what drugs he was prescribed in the community on previous occasions. As a result, the diazepam was not initially prescribed at all and was later prescribed at a lower dose than he had been receiving in the community. In addition, he was prescribed both methadone and dihydrocodeine (both opiates), and the methadone prescription was for an increasing dose. The clinical reviewer considers that this was an error.

56. When Mr Williams said that he felt unwell on 28 December, this was attributed to opiate withdrawal. However, the clinical reviewer said that his symptoms could equally have been due to benzodiazepine withdrawal as Mr Williams had not been receiving his diazepam.

57. The clinical reviewer also found that the medication reconciliation exercise on 28 December resulted in Mr Williams being prescribed more drugs that can cause respiratory depression (diazepam and pregabalin) in addition to the methadone and amitriptyline he was already receiving. She said that this led to a fatal outcome for Mr Williams.

58. Also on 28 December, a prison GP wrote in the medical records that Mr Williams' clinical observations should be monitored and that he should be checked twice a day for drowsiness. He noted that if Mr Williams became drowsy, healthcare staff should stop the methadone, diazepam, pregabalin, amitriptyline and seek advice. He also requested an ECG. Healthcare staff should have taken the actions the GP requested but did not do so. The GP did not add an electronic 'task' which would have acted as an additional prompt.

59. We are very concerned that Mr Williams was not monitored appropriately given the complexity of the medications he was taking. Mr Williams was detoxing from drugs and should have had his vital sign observations taken twice a day. There is no record of this in his electronic medical record and the clinical reviewer noted that there appear to have been days, including the day of Mr Williams' death, when his methadone was dispensed without any physical health checks being recorded. The clinical reviewer said that these checks are a standard requirement when initiating methadone.

60. We make the following recommendations:

The Head of Healthcare and the lead GP at HMP Wormwood Scrubs should meet the two GPs involved in this case and review the clinical care provided to Mr Williams with them in a structured way.

The Head of Healthcare at HMP Wormwood Scrubs should ensure that all prescribers of medication consider the effects of prescribing multiple medications which affect breathing, to ensure that:

- **there is a clear risk/benefit analysis; and**

- **there is appropriate clinical oversight and that vital sign observations are carried out as required.**

Emergency response

61. When staff found Mr Williams unresponsive in his cell, they appropriately called an emergency code blue, which alerted medical staff to attend. CPR was started immediately, while Mr Williams remained on the bed.

62. CPR should be administered on a hard, flat surface. When this was discussed at interview it became apparent that there was not enough room on the cell floor or on the landing to administer CPR. Staff told the investigator that the mattress was relatively firm and that, while doing CPR on the bed was not ideal, they felt that this was the best option to administer medical treatment. We are satisfied that staff administered CPR to the best of their ability.

63. We make no recommendation.

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