

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Harold Uzomechina a prisoner at HMP Wormwood Scrubs on 24 April 2016

**A report by the Prisons and Probation Ombudsman**

## 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 Harold Uzomechina died from aspiration pneumonia arising from methadone toxicity, at HMP Wormwood Scrubs. He was 34 years old. I offer my condolences to Mr Uzomechina's family and friends.

Mr Uzomechina had recently arrived in prison and was undergoing drug and alcohol detoxification. It is possible that he exaggerated his substance misuse to reception staff. I am concerned that healthcare staff did not review his previous medical history, or use objective assessment tools to assess his symptoms while managing his drug treatment.

When Mr Uzomechina's cellmate in the prison's detoxification unit reported abnormally loud snoring during the night before his death, prison staff appeared to be unaware of the possibility that such snoring might have been a sign of drug toxicity.

I am also concerned that staff did not follow all the expected emergency response procedures, leading to delays in calling an emergency code and escorting paramedics to Mr Uzomechina's cell.

This version of our report, published on our website, has been amended to remove the names of staff and prisoners involved in our investigation.

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**June 2019**

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# Summary

## Events

1. Mr Harold Uzomechina was remanded to HMP Wormwood Scrubs on 20 April 2016. At reception health screens, he reported several physical and mental health problems, as well as longstanding dependence on drugs and alcohol.
2. A prison GP prescribed methadone to manage Mr Uzomechina's heroin dependency, chlordiazepoxide for alcohol withdrawal and other medications for relief of symptoms and Mr Uzomechina began detoxification in the prison's substance misuse stabilisation unit. At a GP review on 22 April, Mr Uzomechina appeared well and there were no concerns.
3. At around 11.35pm on 23 April, Mr Uzomechina's cellmate called night staff and asked to move cells, as Mr Uzomechina was snoring so loudly that it was keeping him awake. He was told that a move was not possible during the night.
4. At 8.55am on 24 April, officers tried to wake Mr Uzomechina to attend church. They could not rouse him and sent a colleague to get a nurse. When the nurse arrived, an officer called a code blue emergency and the control room immediately called an ambulance. Nurses and prison staff began cardiopulmonary resuscitation. They found that Mr Uzomechina's jaw was locked and some of his limbs were stiff. They continued the resuscitation attempts until paramedics arrived. The paramedics noted Mr Uzomechina had signs of rigor mortis and confirmed his death at 9.32am

## Findings

5. It was not Mr Uzomechina's first time in prison and healthcare staff at other prisons had found his accounts of his medical history to be inconsistent and inaccurate. In particular, on previous remands, he had not reported any substance misuse or mental health issues. Healthcare staff at Wormwood Scrubs had not reviewed his past records, so were unaware of his propensity to make false claims and show drug seeking behaviours and they did not use objective scoring tools to assess his symptoms. It is possible that Mr Uzomechina exaggerated his substance misuse in order to obtain drugs.
6. The prison staff to whom Mr Uzomechina's cellmate reported his loud snoring were seemingly not alert to the possibility that this might have been a symptom of drug-induced unconsciousness. Non-medical staff at the prison had not been able to take up offers of training on substance misuse issues. We consider that staff working on a specialist unit where prisoners are undergoing detoxification should be aware of the signs and symptoms of drug toxicity.
7. Some aspects of the emergency response were not conducted promptly. The officers who found Mr Uzomechina unresponsive did not immediately call an emergency code and waited for a nurse to attend. It took 13 minutes to escort the second paramedic crew from the prison gate to the cell. Although this did not affect the outcome for Mr Uzomechina, speed of response could be vital in a future emergency.

8. Healthcare staff ignored clear signs of rigor mortis and inappropriately attempted to resuscitate Mr Uzomechina. The emergency response nurse thought that he had to continue resuscitation until a person qualified to certify death arrived. It is important that staff feel confident to either not attempt, or discontinue resuscitation when there is conclusive evidence that it would be futile.

## Recommendations

- The Head of Healthcare should put in place auditable processes to ensure that healthcare staff review the previous medical records of prisoners undergoing combined alcohol detoxification and methadone stabilisation; and routinely use objective scoring tools to assess such prisoners.
- The Governor and Head of Healthcare should ensure that all staff working with prisoners on the substance misuse stabilisation unit are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication and know how to respond.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including:
  - using the appropriate emergency code to effectively communicate the nature of a medical emergency and enable staff to take the relevant equipment to an emergency; and
  - ensuring there is no unnecessary delay in escorting ambulances and paramedics.
- The Head of Healthcare should ensure that all healthcare staff are aware of the signs of rigor mortis; fully understand the circumstances in which resuscitation is inappropriate; and are confident about applying the European Resuscitation Council Guidelines on resuscitation appropriately.

## The Investigation Process

9. 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.
10. The investigator obtained copies of relevant extracts from Mr Uzomechina's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Uzomechina's clinical care at the prison.
12. The investigator interviewed two prison officers at Wormwood Scrubs on 12 September 2016. She then jointly interviewed five healthcare staff, with the clinical reviewer, on 22 September 2016 and 13 November 2018.
13. Our investigation was suspended for several periods between 6 May 2016 and 11 March 2019, while waiting for additional reports relating to the cause of death. This report was delayed as a result. Another investigator took over the latter stages of the investigation.
14. We informed HM Coroner for West London of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Uzomechina's mother, to explain the investigation and to ask if there were any matters she wanted the investigation to consider. She raised no specific issues for us to consider.
16. We sent a copy of the report to the solicitors representing Mr Uzomechina's mother. The solicitors raised several issues which have been addressed in correspondence.
17. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies. The HMPPS action plan has been annexed to this report.

## Background Information

### HMP Wormwood Scrubs

18. HMP Wormwood Scrubs is a local prison in West London, holding nearly 1,300 men. The prison holds men on remand from West London courts and London prisoners serving short sentences or coming to the end of long sentences. Care UK is contracted to provide primary care and several other health services at Wormwood Scrubs. Registered nurses are available 24 hours a day. (At the time of Mr Uzomechina's death, Central London Community Healthcare provided healthcare services.)
19. 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 establishment and enhancing the leadership and training available to staff.

### HM Inspectorate of Prisons

20. The most recent inspection of HMP Wormwood Scrubs was conducted in July and August 2017. Inspectors reported that staff shortages and the lack of experienced staff affected all aspects of the prison and made it difficult to provide even basic services.
21. Inspectors reported that the healthcare service was reasonably good and that staff were professional and caring. Provision for newly-arrived prisoners with drug and alcohol problems had improved and was good. They were identified quickly, prioritised for the doctor and accommodated in the substance misuse stabilisation unit, where they were monitored and supported.

### Independent Monitoring Board

22. 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 2017, the IMB reported that Wormwood Scrubs had made real progress during the past year, but there were still very serious problems. Overall, the quality of clinical care was acceptable. However, owing to staff shortages, screening for newly-arrived prisoners in the First Night Centre was sometimes late or missed.

### Previous deaths at HMP Wormwood Scrubs

23. Mr Uzomechina was the third prisoner of 15 to die at Wormwood Scrubs since January 2016. We have raised the issues of reviewing medical records, use of emergency response codes and inappropriate resuscitation attempts in previous investigations at the prison.

## Key Events

24. On 20 April 2016, Mr Harold Uzomechina was remanded to HMP Wormwood Scrubs, on charges of assault. It was not his first time in prison.
25. At his initial health screen, Mr Uzomechina reported to a nurse that he had a slipped disc and mental health problems, including anxiety-related chest pain, depression and schizophrenia. He said he had previously received psychiatric treatment, had attempted suicide in the past month and was a heavy drinker (more than nine units per day). The nurse noted that Mr Uzomechina was taking medication for his various physical and mental health conditions and that he had tested positive for cocaine. He referred him to the prison GP and to the mental health team for assessment.
26. A prison GP then reviewed Mr Uzomechina, who repeated much of his medical history, in greater detail. Mr Uzomechina said that he had misused drugs and alcohol since the age of 18, spending around £100-£200 daily on crack cocaine and heroin. He added that his hands shook and he had alcohol withdrawal seizures if he stopped drinking. He claimed the last episode of seizures was two days before at the police station, and that he had run out of his medication for schizophrenia. The GP noted that urine tests were positive for morphine, benzodiazepines and cocaine.
27. Neither the nurse nor GP used objective scoring systems, such as the Clinical Opiates Withdrawal Scale (COWS), or the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-A) to assess the severity of Mr Uzomechina's symptoms.
28. The GP prescribed medication for drug and alcohol detoxification - methadone (a synthetic opiate to manage heroin dependency) and chlordiazepoxide (for alcohol withdrawal). He also prescribed several medications for symptom and pain relief, including sodium valproate (a drug used to treat epilepsy and prevent seizures).
29. Reception staff opened the Assessment, Care in Custody and Teamwork (ACCT) procedures (the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm), as Mr Uzomechina had reported a history of self-harm and felt at risk of harming himself. (After an assessment and two case reviews, it was closed on 22 April.)
30. On 21 April, Mr Uzomechina was moved from the First Night Centre to the Conibeere Unit (the substance misuse stabilisation unit) where he was monitored.
31. On 22 April, a nurse carried out a mental health assessment. He noted that Mr Uzomechina had been referred to the mental health in-reach team because of his claims of severe schizophrenia. The nurse requested Mr Uzomechina's community medical records and planned to discuss him at the multidisciplinary team meeting on 27 April.
32. The prison GP then reviewed Mr Uzomechina. He recorded that further to his entry of 20 April, there were no other concerns. Mr Uzomechina was calm, engaged and interacted well. The GP noted that he would be reviewed as

required, or if any concerns arose. There were no significant entries in the medical record after 22 April.

### Events on 23/24 April 2016

33. At around 11.35pm on 23 April, Mr Uzomechina's cellmate pressed the cell call bell. He told an Operational Support Grade (OSG) that Mr Uzomechina was snoring so loudly that he could not sleep and asked to move cells. The OSG contacted an officer, who went to the cell at 12.20am (24 April). The officer told Mr Uzomechina's cellmate that cells were only opened at night in an emergency and that he would ask the day staff to deal with it. Mr Uzomechina's cellmate appeared to accept this. The officer heard faint snoring in the background while speaking to Mr Uzomechina's cellmate.
34. At 6.00am, the OSG signed to confirm completion of the early morning count of prisoners. Mr Uzomechina's cellmate's complaint about Mr Uzomechina's snoring was reported at the handover to day staff.
35. At 8.55am, Officer A tried to wake up Mr Uzomechina to attend church, by shouting through his cell hatch. She tried again a few minutes later, but he did not respond. At around 9.00am, she asked Officer B to go into the cell. The officer shouted Mr Uzomechina's name. His cellmate heard him and woke up, but there was no response from Mr Uzomechina. Officer B then went into the cell and touched Mr Uzomechina's shoulder. There was no reaction and he could see no breathing, or chest movement. Officer C was passing the cell and Officer A asked him to get a nurse.
36. The unit nurse arrived at the cell and Officer A then radioed a code blue (which indicates that a prisoner is unresponsive, or has breathing difficulties) at 9.03am. The control room called an ambulance immediately.
37. Two nurses and other staff responded to the code blue. A prison GP also attended.
38. At interview, one of the nurses said that Mr Uzomechina was warm and a temperature taken in his right ear was normal at 37.2 degrees. The nurses found no pulse and began chest compressions, in rotation, assisted by prison staff. They also attached a defibrillator, which advised no shock. The nurses were unable to insert an airway, as Mr Uzomechina's jaw was stiff, so they gave oxygen through a mask. The nurses said that they had noticed other signs of rigor mortis, such as stiffness of one of his arms.
39. The first crew of paramedics arrived at the prison at 9.14am and reached the cell quickly. Another crew arrived at 9.17am and it took 13 minutes for them to get from the gate to Mr Uzomechina.
40. The paramedics noted that Mr Uzomechina was obviously dead and found rigor mortis in his jaw, arms and legs. They took his temperature on both sides, which was 37.2 degrees on the right and 34.2 degrees on the left (this suggested that he had been dead for some time and the difference in temperature was attributed to his right side being under his duvet). The paramedics noted that resuscitation attempts were futile and confirmed Mr Uzomechina's death at 9.32am.

## Contact with Mr Uzomechina's family

41. A prison manager went to the home of Mr Uzomechina's sister to break the news of his death. A police sergeant went with him. The time was not recorded, but the manager believed that it was around lunchtime. No one was at home, but they checked with neighbours that it was the correct address before returning to the prison.
42. Due to concern that Mr Uzomechina's sister would find out about her brother's death through other prisoners, or the media, the manager called her mobile phone. Although she was at church, the manager felt he had to inform her, as she wanted to know why he had called. Mr Uzomechina's sister was unaware that her brother was in prison. Members of the church supported her after she was given the news.
43. The prison assigned a prison manager as family liaison officer. He and the other manager then went to the church to speak to Mr Uzomechina's sister in person. An OSG took over as family liaison officer on 19 April. He kept in touch with Mr Uzomechina's sister and mother over the following weeks.
44. Mr Uzomechina's funeral was held on 6 July. In line with national policy, the prison contributed to the funeral expenses.

## Support for prisoners and staff

45. After Mr Uzomechina's death, a 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.
46. The prison posted notices informing staff and other prisoners of Mr Uzomechina's death and offering support.

## Post-mortem report

47. The post-mortem report indicated that the probable cause of Mr Uzomechina's death was, 1a. aspiration pneumonia; 1b. cardiorespiratory depression; 1c. methadone toxicity.
48. Aspiration pneumonia is caused by breathing in a vomit, a foreign object, or a harmful substance. The toxicology report stated that the dosage of methadone prescribed was compliant with the UK guidelines on the clinical management of drug misuse and dependence in a prison environment and was the safer option for when tolerance is low or uncertain. The toxicologist added that:

“Nausea and vomiting are common symptoms at the start of methadone treatment and provide a potential explanation for the presence of vomit in this case. A potential series of events could be that the methadone caused respiratory depression and vomiting and, due to the respiratory depression, the deceased aspirated the vomit, leading to pneumonia.

Therefore, whilst I cannot say for certain, the combination of a significant concentration of methadone and the presence of chlordiazepoxide could

have resulted in potentially fatal respiratory depression leading to aspiration pneumonia.”

# Findings

## Clinical care

### *Drug treatment*

49. When Mr Uzomechina arrived at Wormwood Scrubs, he reported several physical and mental health problems, as well as dependence on drugs and alcohol since the age of 18. This was not his first time in prison and entries by healthcare staff during previous periods in custody indicated that his accounts of his medical history were inconsistent, inaccurate and confusing. (Notably, on reception to HMP Manchester and HMP Wandsworth in 2012 and 2015, respectively, Mr Uzomechina had reported no substance misuse or mental health issues.)
50. Mr Uzomechina began alcohol and drug detoxification. The drugs and dosages prescribed were in line with national guidance at that time. However, the clinical reviewer indicated that healthcare staff had used no objective scoring tools, such as the Clinical Opiates Withdrawal Scale (COWS), which assesses opiate withdrawal symptoms, or the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-A) to assess the severity of alcohol withdrawal. Neither had they reviewed Mr Uzomechina's medical records, so they were unaware of his previous untruthful claims about his medical history and drug seeking behaviours. The toxicologist and the clinical reviewer considered it likely that Mr Uzomechina had exaggerated his drug and alcohol use to obtain drugs.
51. We acknowledge that there has been a significant lapse of time since Mr Uzomechina's death and individual practice might have improved. However, the review of records and use of assessment tools are fundamental clinical tasks that should have been carried out. We make the following recommendation:

**The Head of Healthcare should put in place auditable processes to ensure that healthcare staff review the previous medical records of prisoners undergoing combined alcohol detoxification and methadone stabilisation; and routinely use objective scoring tools to assess such prisoners.**

### **Possible signs and symptoms of drug toxicity**

52. Typically, people who die from the effects of methadone become deeply unconscious, unrousable and are often heard to be snoring heavily before they stop breathing. Although we cannot be certain, it is possible that the loud snoring reported by Mr Uzomechina's cellmate was a symptom of drug-induced unconsciousness. This might have been recognised by trained staff, or if it had been brought to the attention of healthcare staff.
53. It is unclear what training opportunities were available before Mr Uzomechina's death. However, when interviewed in November 2018, Care UK's Regional Manager said that they offer the opportunity for prison officers to attend the Royal College of General Practitioners part 1 course in substance misuse, which covers issues such as identifying abnormal snoring. Additionally, a consultant in substance misuse attends the prison once a month and has conducted training. Neither opportunity for training had ever been taken up by officers, but Care UK's

Regional Manager acknowledged that it might be impractical given that the same officers do not work on the unit all the time.

54. While it is not feasible for non-medical staff to know the signs and symptoms of a range of medical conditions, it would be beneficial for those working on a specialist unit where all prisoners are undergoing drug treatment to be aware of the possibility, signs and symptoms of drug-induced unconsciousness. If there are insufficient resources for formal training, staff should be provided with guidance. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff working with prisoners on the substance misuse stabilisation unit are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication and know how to respond.**

### Emergency response

55. Prison Service Instruction (PSI) 3/2013 *Medical Emergency Response Codes* sets out how a prison should respond to a medical emergency. This includes the expectation that prison staff should request assistance promptly using the relevant medical emergency code. It should not be a requirement for a member of healthcare staff to attend before an ambulance is requested; and there should be no unnecessary delay in escorting ambulances and paramedics to the patient.
56. When officers found Mr Uzomechina unresponsive, they did not immediately call a code blue emergency. They asked another officer to get a nurse and they radioed a code blue after the nurse arrived. Use of a code enables healthcare staff to bring the correct equipment and alerts the control room to call an ambulance. At interview, Officer A said that she was unsure and wanted the nurse to check Mr Uzomechina before calling a code blue.
57. The control room contacted the ambulance service immediately after the code blue. On arrival, the first paramedic crew were escorted to the cell quickly, but it took 13 minutes for the second crew to reach the cell. While it would not have made a difference for Mr Uzomechina, we consider that this was too long to get paramedics from the prison gate to his cell in an emergency - longer than it had taken for them to get to the prison.
58. Prison staff did not comply with key aspects of the emergency response guidance and it is of particular concern that we have made several recommendations to Wormwood Scrubs about the need to use a code in a medical emergency. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including:**

- **using the appropriate emergency code to effectively communicate the nature of a medical emergency and enable staff to take the relevant equipment to an emergency; and**
- **ensuring there is no unnecessary delay in escorting ambulances and paramedics.**

## Resuscitation

59. European Resuscitation Council (ERC) Guidelines for Resuscitation 2015, say that “resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”. The guidelines define examples evidence of futility as including the presence of rigor mortis. Every decision should be made on the basis of a careful assessment of an individual’s situation. The ERC guidance was shared with prison managers in September 2016, after Mr Uzomechina’s death.
60. Healthcare and prison staff attempted to resuscitate Mr Uzomechina for some time, despite common signs of rigor mortis such as a locked jaw and stiff limbs. The staff placed more importance on his body being warm and a temperature reading taken in one ear. One of the nurses said he thought that he was required to continue resuscitation until a clinician qualified to certify death arrived.
61. Care UK’s Regional Manager said that the issue of resuscitation was covered in the Intermediate Life Support course undertaken by healthcare staff and they receive ongoing support and encouragement in determining when resuscitation is futile. She recognised that their practice required a culture change.
62. We understand the wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out cardiopulmonary resuscitation in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

**The Head of Healthcare should ensure that all healthcare staff are aware of the signs of rigor mortis; fully understand the circumstances in which resuscitation is inappropriate; and are confident about applying the European Resuscitation Council Guidelines on resuscitation appropriately.**

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