	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Senior Governor, HMP Wormwood Scrubs.
1	CORONER I am Sarah Ormond-Walshe, Assistant Coroner, West London jurisdiction
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	INQUEST On 6 April 2016 the court opened an investigation into the death of John Kevin O'MEARA. He had died on 29th March 2016. The inquest was concluded on 9th October 2017
4	CIRCUMSTANCES OF THE DEATH A jury found: That the medical cause of death was: 1a. Respiratory Depression 1b Methadone in Conjunction with other drugs 2 History of Alcohol and Drug Misuse and Evidence of Liver Damage How, when and where: Between 12.00 and 14.20 on 29/03/16, the deceased suffered a respiratory failure whilst in cell R4-05 of the Conibeere Unit in HM Prison Wormwood Scrubs. Attempts were made to resuscitate. The deceased was pronounced dead 15.17. Mr O'Meara was housed in the Conibeere Unit of HM Prison Wormwood

	Scrubs after detailing a history of drug and alcohol misuse on arrest. He was undergoing a drug stabilisation programme involving prescription of Methadone in line with nation guidelines. The Methadone was prescribed following an initial assessment and drug test by clinical staff on his arrival at the prison. In addition, he was prescribed multiple drugs to alleviate and manage symptoms of alcohol withdrawal and mental health issues. Mr O'Meara suffered a catastrophic respiratory failure. He died in part because: 1. Insufficient staffing levels in the Conibeere Unit led to inadequate medical supervision, specifically the omission of the medical monitoring and failure to complete full vital signs checks on the day of his death. 2. A missed opportunity to raise concerns over Mr O'Meara's health following an interaction with prison staff at 12 midday on the day of his death. The Conclusion of the Jury was: Drug Related
5	CORONER'S CONCERNS During the course of the inquest, the evidence revealed matters giving rise to concern that in my opinion mean that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. I have sufficient concern about wider issues which warrant the writing of this Prevent Future Death Report (CJA 2009, Schedule 5, Paragraph 7; Regulation 28 Coroners (Investigations) Regulations 2013) to be sent more centrally. The MATTERS OF CONCERN are as follows. – This is: This inquest has raised two matters which I would like to highlight to the Prison Service. They are not matters, in Mr O'Meara's case, which were necessarily causative of the death, but they are live issues very relevant to the current challenging times Prison Officers are facing in busy and short-staffed prisons: Activation of Code Blue/Red The sad facts leading up to the death of John Kevin O'MEARA have not been the first set of facts where I have heard about a death where the activation of codes has not been immediate.

	I am concerned that Prison Officers are not strictly following the Code Blue/Red system which is meaning there is a delay in the London Ambulance being called. Whilst I can see in many cases that, by the time the prisoner has been found, there may be nothing that can be done to resuscitate them with the number of deaths happening relating to opiate use, the prompt administration of Naloxone is important to give the deceased the best chance; and this is only one resuscitative measure. I gather the current way that Officers are trained is by the use of Notices and Pocket-sized Cards. The Officer finding Mr O'Meara, even after questioning by myself and the Counsel for Interested Persons, left the witness stand still not understanding that by not immediately calling a Code Blue, and despite prison medical staff coming quickly, an ambulance would not have been called. Even presumably having reflected on the case, she did not appear to understand the reason why a Code is called. I am asking for more consideration to be given to ensure the right message is getting across and that Prison Officers understand the importance of and reasons for the use of the codes. Passive Dog Use The Prison GP expert in this inquest was emphatic that Novel Psychoactive Substance played a part in the death. I understand that these drugs can be brought into the prison in a number of ways and one is NPS contaminated paper or even childrens' photographs, arriving into Prisons in the post. I appreciate how challenging it is to control the use of Novel Psychoactive Substances in prisons. So, the use of trained passive dogs is particularly helpful In fact it appears to be one of the only failsafe ways to controlling NPS use in prisons. There are only two at HMP Wormwood Scrubs whereas HMP Highdown has eight. Although dogs can be 'borrowed' from other London prisons when handlers are away, I wish to put on record my support for funding for more of these dogs at this current challenging time.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths. Prison Officers should receive better and/or more training on the prompt activation of Codes Red and Blue at HMP Wormwood Scrubs. More passive dogs should be available at HMP Wormwood Scrubs.

7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Miss Ormond-Walshe. I, the coroner, may extend the period. 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. If you require any further information or assistance about the case, please contact the Coroner's Officer, [redacted]
8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: 1. [redacted] 2. Central London Community NHS Trust 3. North West London NHS Foundation Trust 4. Rehabilitation for Addicted Prisoners Trust I am also 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	10 January 2018 Miss Ormond-Walshe