

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Owen Harris a prisoner at HMP Wormwood Scrubs on 23 June 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 Owen Harris was found hanged in his cell at HMP Wormwood Scrubs on 23 June 2016. He was 25 years old. I offer my condolences to Mr Harris' family and friends.

Mr Harris was at Wormwood Scrubs for less than 36 hours before he died. It is unfortunate that he was not placed on the substance misuse unit following his arrival at the jail where he would have been more closely supervised. Instead, Mr Harris was located on the first night centre and was undergoing an alcohol detoxification programme.

However, Mr Harris gave staff and other prisoners little indication that he was at risk of suicide or self-harm, but the investigation has identified a significant number of weaknesses in his care during his short time at the prison, including reception procedures, location, the emergency response and post-incident arrangements. These issues need to be addressed.

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

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Summary

Events

1. On 21 June 2016, Mr Owen Harris was remanded into custody having been charged with burglary. He was taken to HMP Wormwood Scrubs. He told an officer that he had no thoughts of suicide or self-harm. Staff and prisoners said he seemed cheerful and they had no concerns about him. However, when staff tried to take him to his allocated cell, he became aggressive and threatening towards other prisoners and staff, stating that he did not want to share a cell with someone of another ethnicity. Staff allocated him a single cell and Mr Harris calmed down and apologised. However, due to his agitation, a nurse did not assess him that evening.
2. The next day, a nurse assessed Mr Harris. She did not review his medical record from his time in prison a month earlier, which would have indicated that he had disclosed that he suffered from depression and paranoia. However, Mr Harris told her that he had no mental health issues or thoughts of suicide or self-harm but misused alcohol and cocaine. A doctor assessed Mr Harris, noted he was shaking and sweating, and prescribed alcohol detoxification medication.
3. All prisoners detoxifying from alcohol and drugs should be transferred to the substance misuse unit. However, there was no room for Mr Harris on the unit, so he remained in the first night centre. A nurse gave him his medication three times that afternoon. He was also seen by several prisoners and staff. No one had any concerns about him during the day or the evening. A supervising officer recalled speaking and joking with Mr Harris as he left the prison about 10.00pm.
4. On 23 June, at about 1.25am, an officer started checking all the prisoners on the wing. He found Mr Harris had hanged himself in his cell. He radioed a code blue emergency and two members of staff reached the cell within a minute. Around 40 seconds later, three more members of staff arrived. They unlocked the door, cut the ligature and lowered Mr Harris to the floor. Prison staff attempted to resuscitate him but, at 1.50am, paramedics pronounced Mr Harris dead.

Findings

5. During Mr Harris' short time at Wormwood Scrubs he seemed to be coping well and we are satisfied that staff where he was located could not have reasonably predicted that he presented a risk of suicide. Mr Harris concealed his intentions from those around him. A note found after his death revealed that he could no longer envisage a future for himself.
6. Mr Harris was not assessed by a nurse and a doctor until the day after he arrived at Wormwood Scrubs. At this point, he started an alcohol detoxification programme but there was no space for him on the substance misuse unit. Consequently, he was subject to fewer checks than required when undergoing a detoxification process. Had he been transferred to the substance misuse unit, as he should have, he would have been subject to closer supervision. We can only speculate whether this might have averted his death.

7. He also should have been referred to the mental health team. However, the clinical reviewer concludes that this omission did not clinically affect the outcome for Mr Harris.
8. When staff found Mr Harris, there was a delay of nearly two minutes before they unlocked his cell. This was unlikely to have made a difference to the outcome but may do so with other prisoners in future circumstances. Understandably, staff attempted resuscitation despite the presence of rigor mortis. Some nurses believed they must attempt resuscitation even when there are clear signs that the prisoner was dead. This is not the case.
9. We also found that some prisoners and staff were not adequately supported after Mr Harris' death and the prison did not offer to pay repatriation costs.

Recommendations

- The Governor and Head of Healthcare should ensure that a reception healthscreen takes place on a prisoner's first day in custody. If this does not take place, the reason must be clearly documented in a prisoner's medical record.
- The Governor and Head of Healthcare should ensure that prisoners who require detoxification are transferred to the substance misuse unit.
- The Governor and Head of Healthcare should ensure that healthcare staff review a prisoner's medical record before assessing him.
- The Governor should ensure that staff open cells as quickly as possible when there is an immediate danger to life.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.
- The Governor should ensure a critical incident debrief is held after a potentially traumatic incident or death, and staff and prisoners are offered appropriate and timely support.
- The Governor should ensure that the prison offers to pay reasonable repatriation costs following a death in custody.

The Investigation Process

10. 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.
11. The investigator visited HMP Wormwood Scrubs on 5 July 2016. She obtained copies of relevant extracts from Mr Harris' prison and medical records.
12. The investigator interviewed fifteen members of staff and four prisoners at HMP Wormwoods Scrubs in July. She subsequently interviewed another member of staff by telephone in September.
13. NHS England commissioned a clinical reviewer to review Mr Harris' clinical care at the prison. He conducted some interviews jointly with the investigator.
14. We informed HM Coroner for West London of the investigation and we have given the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Harris' father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked the following questions:
 - What information was taken into account in deciding to locate Mr Harris in a cell on his own and was this decision appropriate?
 - What offence had Mr Harris been charged with?
16. Mr Harris' father received a copy of the initial report. He raised an issue that does not impact on the factual accuracy of this report and has been addressed separately.
17. The National Offender Management Service (NOMS) also received a copy of the report. They accepted all the recommendations.

Background Information

HMP Wormwood Scrubs

18. HMP Wormwood Scrubs is a local prison in west London housing 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.
19. On 1 April 2016, Care UK took over the healthcare contract for primary care and several other health services. There is 24-hour healthcare cover and an inpatient unit with 17 beds. There is a dedicated substance misuse unit for prisoners who require alcohol or drug detoxification. Prisoners here are observed and assessed more regularly than in other areas of the prison and medication intended to minimise any withdrawal symptoms is administered.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wormwood Scrubs was conducted in December 2015. Inspectors had serious concerns about the prison and noted that not nearly enough progress had been made since their inspection 18 months earlier. They concluded that safety at the prison had deteriorated and that prisoners' poor experiences began on arrival at the prison, with a large number of prisoners arriving late in the day. This undermined the ability of reception and healthcare staff to identify risks and needs.
21. The inspectors were concerned that not all prisoners received all essential first night procedures during the busier times. Some prisoners who arrived in reception late did not always receive an initial health screening to identify immediate health needs until the following day. They also noted that inadequate arrangements for prisoners who required alcohol detoxification were particularly dangerous. Prisoners arriving after 7.00pm were not guaranteed to see a doctor, go to the detoxification unit or be prescribed the necessary detoxification medicine on their first night.

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 most recently published annual report for the year to May 2016, the IMB said that the prison had had a chaotic first six months followed by a determination to improve standards in the second half of the year. They were also concerned that prisoners who were detoxifying were sometimes not assessed or prescribed medication on their first night in custody.

Previous deaths at HMP Wormwood Scrubs

23. Since 2012, we have investigated the deaths of 17 prisoners at Wormwood Scrubs, including that of Mr Harris. Nine of these deaths were apparently self-inflicted. We identified an issue in this, and a number of previous investigations, concerning staff understanding of the resuscitation policy.

Incentives and Earned Privileges (IEP) Scheme

24. Each prison has an Incentives and Earned Privileges scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

25. On 14 May 2016, Mr Owen Harris was remanded to HMP Thameside. Mr Harris told staff he had no mental health or alcohol and drug issues and no thoughts of suicide or self-harm. On 20 May, he was moved to HMP Pentonville. He told an officer that it was his first time in an English prison, although he had previously been in prison in Ireland, where he had been violent towards other prisoners and prison officers. He said he had no thoughts of suicide or self-harm. Mr Harris later told a prison GP that he was on medication for mental health problems but he could not remember what the medication was called. He said he suffered from depression and anxiety. Mr Harris said he had no thoughts of suicide or self-harm. The GP prescribed Mr Harris zopiclone for three days to help him sleep, and referred him to the mental health in reach team (MHIRT).
26. On 26 May, an occupational therapist assessed Mr Harris. He said he was not happy due to being in prison but felt stable. He said he had no current or previous thoughts of suicide or self-harm but was only sleeping for around four hours each night. He said he had been prescribed seroquel (antipsychotic medication) from a young age and suffered from depression and paranoia. He said he occasionally used cannabis and cocaine. On 1 June, Mr Harris returned to court and was released on bail.
27. On 18 June, Mr Harris was arrested for burglary. He was charged on 20 June and held in police custody until his court appearance the following day.

21 June

28. On 21 June, Mr Harris appeared at court and was remanded into custody until 19 July. Mr Harris was taken to HMP Wormwood Scrubs where he arrived at 6.00pm. An officer completed a document entitled "Reception Safer Custody Checklist" with Mr Harris' name, prisoner number and the date. The officer drew lines through sections asking whether the prisoner had any thoughts of suicide and self-harm and misused drugs or alcohol.
29. The officer told the investigator that he could not specifically remember Mr Harris but that the lines indicated that Mr Harris said he had no issues in these areas. He also completed a cell sharing risk assessment (CSRA) which is designed to assess the risk of violence a prisoner poses. The officer circled "yes" to racially motivated crime and violence in prison. He said this was based on the answers that Mr Harris gave him. However, he said that prisoners often gave answers intending to secure themselves a single cell and if there was no information to substantiate their claims he would still assess them as suitable to share a cell. This was his assessment of Mr Harris.
30. Staff took Mr Harris from reception to the first night centre where he had a short group induction. The investigator spoke to four prisoners employed in the first night centre. They described Mr Harris as calm, compliant, cheerful, lively, and chatty over the time that he was there.
31. Around 9.00pm, Mr Harris became aggressive with a custodial manager as he was taking him to his cell, which was shared. Mr Harris said that he would stab his cellmate if he had to share with anyone who was not Irish. There was no one

in the cell at the time. A Senior Officer (SO) heard Mr Harris and went to assist his colleague. He said Mr Harris was loud and verbally aggressive towards staff and other prisoners. The SO allocated Mr Harris a cell on his own due to the risk he presented to other prisoners and reduced his Incentives and Earned Privileges (IEP) level to basic. This meant the removal of Mr Harris' television.

32. Later that evening, Mr Harris rang his cell bell and apologised to the custodial manager for his behaviour and stated he was worried that he would not cope sharing a cell with someone of another ethnicity. On account of his behaviour, Mr Harris was not assessed by a nurse that evening. A note in a reception book indicates that he was not seen due to "safety issues". Staff did not enter this information in his medical record.

22 June

33. On 22 June, around 8.30am, an officer unlocked Mr Harris for his group induction. He said that Mr Harris was helpful, calm and seemed in "good spirits". After his induction, Mr Harris was allowed some association time. This allows prisoners to mix with each other, have showers, make telephone calls, and complete other domestic tasks. An offender supervisor assessed Mr Harris that morning. He said Mr Harris seemed jovial and quite happy. He had no concerns that Mr Harris was a risk to himself.
34. A nurse was working in the first night centre that morning and had a list of healthscreens to complete. She told the investigator that Mr Harris' healthscreen was not the only one from the day before that had not been conducted. The nurse did not review Mr Harris' previous medical record. She told the investigator she would only do so if it was necessary because of what a prisoner told her.
35. The nurse completed Mr Harris' initial healthscreen around 9.25am. Mr Harris told her that he misused alcohol and drank ten units or more daily. He also said that he snorted cocaine daily and had last used cocaine two days earlier. The nurse observed that Mr Harris was sniffing due to a cocaine craving and was shaking due to alcohol withdrawal. Mr Harris told the nurse he had no thoughts of suicide and self-harm. He told her that he was feeling alright but was missing cocaine. Mr Harris said he was not registered with a GP in the community. The nurse referred Mr Harris to the prison doctor due to his alcohol and drug misuse.
36. At 10.48am, a prison GP assessed Mr Harris. The doctor told the investigator that she could not remember whether she had read Mr Harris' medical record before she saw him but did check his initial healthscreen. Mr Harris told her that he drank seven pints of beer and some spirits on a daily basis. He said he needed a drink of alcohol in the morning to stop him shaking. Mr Harris also said he used £150 worth of cocaine daily and was not taking any medication. She observed that Mr Harris was shaking and had sweaty hands and needed alcohol detoxification medication. The results of a urine drug screening were negative so the doctor prescribed Mr Harris chlordiazepoxide (for treating alcohol withdrawal symptoms), thiamine and vitamin B.
37. The GP told the investigator she could not remember whether she asked Mr Harris whether he had any thoughts of suicide or self-harm. She said that he

presented as calm and coherent, with good eye contact and she had no concerns that he was a risk to himself.

38. At 11.15am, Mr Harris asked an officer if he could telephone his partner. The officer agreed and allowed him to use the telephone which was limited to two-minute calls. Mr Harris rang his partner. He told her where he was and he said he would like her to visit him. She said she would try to visit within the next two days. The telephone then cut out. Mr Harris asked the officer for another two minute telephone call, to which he agreed. Mr Harris and his partner discussed her visiting again. Mr Harris said his solicitor thought he would receive an 18 month custodial sentence, which would mean he would spend nine months in prison. Mr Harris told his partner he missed her and the telephone cut out again. Mr Harris thanked the officer and returned to his cell.
39. A Supervising Officer (SO) told the investigator that Mr Harris was interacting well with other prisoners that morning. The SO was not informed that Mr Harris was withdrawing from alcohol. Staff locked Mr Harris in his cell over the lunchtime period.
40. A prisoner told the investigator that he talked to Mr Harris through the observation panel that afternoon. Mr Harris asked him about the prison and which wing was best to live on. The prisoner, who is a Listener (prisoners trained by the Samaritans to support other prisoners), said that Mr Harris seemed relaxed and he had no concerns that he was a risk to himself. He asked Mr Harris whether he wanted to see him in his capacity as a Listener but Mr Harris declined and said that he was coping. He also asked Mr Harris whether he had any suicidal thoughts. Mr Harris said he did not; he had been in prison before and would get through this sentence.
41. That afternoon, an officer telephoned the substance misuse unit to see how many spaces they had. They confirmed that they had six spaces. The officer was aware that they had seven prisoners who needed to go there. He therefore asked a nurse to assess the prisoners to determine who should remain on the first night centre. Having reviewed their medical records, the nurse decided that Mr Harris should remain on the first night centre. She told the investigator this was because he was withdrawing from alcohol, not drugs and therefore did not need to be prescribed methadone, which could only be given once on the substance misuse unit.
42. The officer explained to Mr Harris that he could not move to the substance misuse unit straight away, as there was no space. He told him that although he was still subject to the basic regime he could have his television back as he had complied with staff that day. The officer said Mr Harris seemed very pleased about this and thanked him. He said Mr Harris was displaying no obvious physical withdrawal symptoms from alcohol.
43. A nurse was responsible for giving out medication that afternoon. When Mr Harris came to the medication hatch, the nurse told the investigator that he seemed happy, was joking and asking her questions. She noticed he was sweating but displayed no other obvious withdrawal symptoms from alcohol. She asked how he was, to which he replied that he was fine. She gave him his chlordiazepoxide around 2.30pm and he returned to his cell.

44. Staff unlocked Mr Harris for a shower that afternoon. Mr Harris asked an officer for some spare clothes as he only had the ones he was wearing. The officer said he would get some for Mr Harris in the morning. Another officer gave him his dinner at the servery. He told the investigator that Mr Harris was talking to other prisoners and he had no concerns about him. Another officer then locked him back in his cell.
45. A nurse gave Mr Harris his next dose of chlordiazepoxide at 6.00pm. This was logged at the later time of 7.20pm on the computerised record due to technical issues. She also gave Mr Harris his daily dose of thiamine and vitamin B. At 8.00pm, she gave Mr Harris his last dose of chlordiazepoxide through his observation panel. She said he seemed fine and was writing something.
46. Several members of staff and prisoners recalled Mr Harris watching Ireland playing in a World Cup football match on his television that evening. The game started at 8.00pm and staff and prisoners said Mr Harris was cheering as Ireland scored and won the game. They said he seemed happy and shared jokes with some of them. Mr Harris asked another prisoner for some writing paper through his observation panel, which the prisoner gave him.
47. An officer left the prison around 9.00pm. He said goodnight to Mr Harris, who was standing at his observation panel, on his way out. He said Mr Harris seemed "happy". Another officer left the wing 20 minutes later. He said goodnight to Mr Harris and told him he would get him his spare clothes in the morning. Mr Harris thanked the officer.
48. The SO left the prison around 10.00pm. On his way out, Mr Harris spoke to him through his observation panel and they shared a joke. Mr Harris said he would see the SO tomorrow. Officer A began his shift in the prison at 8.30pm. He was working in various parts of the prison until sometime after 10.00pm when he was located to the first night centre. He recalled turning the lights off in the corridor of the centre around 11.30pm.

23 June

49. On 23 June at 12.50am, Officer A checked the prisoners in the cells opposite Mr Harris, as they were subject to suicide and self-harm monitoring. At around 1.25am, the officer said he had a feeling something was not right, so he decided to check all 16 cells in the wing. Mr Harris' was the third cell he reached. Through the gap around the doorframe, he could see that Mr Harris' cell light was on, which was unusual at that time of night. He had not noticed this before.
50. The officer looked through the inundation point in the door below the observation panel, and saw that Mr Harris was not in bed. He then opened the observation panel and saw Mr Harris had hanged himself with a piece of bed sheet tied to the window bar. He was facing the officer with his feet suspended off the floor and head to one side. The officer told the investigator he knew Mr Harris was dead from his facial appearance. CCTV footage from the first night centre shows that he opened Mr Harris' observational panel at 1.29.42am.

51. The officer said he was extremely shocked by what he saw and needed to compose himself. He ran to the induction room across the corridor. He radioed the control room and reported a code blue on the first night centre with a prisoner hanging and unresponsive. A code blue indicates a medical emergency in circumstances such as when a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically. The control room immediately telephoned an ambulance.
52. An officer heard the code blue and immediately went to the first night centre, arriving at the same time as her colleague. CCTV shows all three officers arriving and looking into the cell at 1.30.44am. Officer A went to check the other prisoners on the wing. CCTV showed two officers also left the cell. At 1.31.18am they returned, along with two nurses and a custodial manager. Five seconds later, an officer unlocked the door. This was just under two minutes after Officer A had first found Mr Harris.
53. All the staff went into the cell and the custodial manager cut the ligature while an officer and a nurse supported Mr Harris. Both nurses observed Mr Harris' pupils were dilated, and that rigor mortis, and other signs of death, were present. An officer cut the ligature from Mr Harris' neck and they lowered him to the floor.
54. The nurses confirmed Mr Harris was not breathing and had no pulse and started CPR. One nurse inserted an airway and administered oxygen by an ambubag while the other continued with chest compressions. They connected the defibrillator, which indicated that no shock should be given and therefore continued CPR until the paramedics arrived at 1.44am. At 1.50am paramedics pronounced Mr Harris dead. London Ambulance Service documentation indicates that rigor mortis and hyperstasis (the accumulation of blood in the lower part of the body or organs) were evident and CPR was not therefore attempted the paramedics.
55. Mr Harris had left notes in his cell addressed to his partner and siblings. These indicated that he was going to kill himself because he thought life was getting tougher and he could not envisage a future for himself. He wrote that he was not going to kill himself because of the prison.

Contact with Mr Harris' family

56. On 23 June, at 7.45am, the Deputy Governor appointed a custodial manager as the family liaison officer. No next of kin were noted in Mr Harris' records. The custodial manager checked the prison telephone system and obtained the details of Mr Harris' partner and father. The latter had an Irish telephone number. He called the Irish Embassy to ask them to inform Mr Harris' father of his son's death. They later returned his call to inform him that they had done so in person, with the assistance of the local police, at his home address.
57. The custodial manager listened to the telephone call Mr Harris had made to his partner on 22 June. This indicated that she might be visiting the prison on 23 June and therefore the custodial manager did not want to leave the prison. To avoid any potential delay, he asked the police to go to her address and inform her of the news. The police did so and informed Mr Harris' partner of his death.

She then telephoned the custodial manager, who met her at a local police station where he offered his condolences and support. The prison contributed to Mr Harris' funeral costs in line with Prison Service instructions. However, Mr Harris' father said that the prison did not offer to pay repatriation costs. He had approached his local MP about this matter and a charity met these costs.

Support for prisoners and staff

58. After Mr Harris' death, a senior 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. Some nurses who had not been involved in the emergency response but had assessed and had contact with Mr Harris told the investigator that they did not know where to access support, nor had they been offered any. No further debrief was held.
59. The prison posted notices informing other prisoners of Mr Harris' 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 Harris' death.
60. An officer told the investigator that she spoke to the four prisoners employed on the first night centre on 24 June. She apologised for no one speaking to them before that time, explained the circumstances surrounding Mr Harris' death and offered them support and counselling.

Post-mortem report

61. The investigator had not yet received a copy of the post-mortem report at the time of writing but was informed by the coroner that the preliminary cause of death was hanging.

Findings

Assessment of Mr Harris' risk of suicide and self-harm

62. Mr Harris consistently told both staff and prisoners that he had no current thoughts or previous history of attempted suicide or self-harm. He appeared to be coping well in prison. Staff and prisoners the investigator spoke to said Mr Harris was chatty, happy and joked with them. Nobody had any concerns that he presented a risk to himself and Mr Harris' death was a shock to all those who had met him. He wrote notes to his family that he had decided to kill himself as he could not see a future for himself and that this had nothing to do with the prison. Unfortunately, Mr Harris successfully concealed his intention from those around him.
63. Although there were some factors that increased Mr Harris' risk of suicide such as his mental health issues, detoxification from alcohol and the fact that he had just been remanded to prison, we do not consider that these issues warranted Mr Harris being assessed as a risk to himself. In these circumstances, we conclude it was reasonable that Mr Harris was not managed within Prison Service suicide and self-harm prevention procedures.

Delay in healthcare screening

64. Prison Service Instruction (PSI) 07/2015, *Early Days in Custody*, instructs that:

“prisoners who are about to spend their first night in prison custody must undergo a detailed medical examination before lock-up to assess their physical and mental health, including any safer custody concerns or substance abuse issues, and to determine whether there are any clinical needs that must be followed up.”
65. There is no reason given in Mr Harris' medical record as to why he did not receive a medical assessment on the first day he was in prison. An entry was made in the reception book that this was due to “safety issues”, presumably after he became aggressive with staff when being locked in his cell. We recognise that there is a finely balanced decision to make between staff safety and the needs of a prisoner. Mr Harris calmed down quickly after the incident and apologised to staff. A healthscreen could have potentially taken place at this point. We are concerned that the nurse who completed his healthscreen the next morning disclosed that Mr Harris' was one of several healthscreens that had not been completed the night before. Additionally, the last HMIP report noted concerns that healthscreens were sometimes not carried out on the first night.
66. We note that the clinical reviewer concluded that the resulting delay in Mr Harris' detoxification treatment did not have a detrimental effect on him. However, Central and North West London NHS Trust's management of alcohol withdrawal guidelines indicate that alcohol withdrawal can be life-threatening and the initial assessment on arrival is of extreme importance. Alcohol detoxification should be commenced at the earliest opportunity. We recommend that:

The Governor and Head of Healthcare should ensure that a reception healthscreen takes place on a prisoner's first day in custody. If this does

not take place, the reason must be clearly documented in a prisoner's medical record.

Detoxification treatment and supervision

67. The clinical reviewer concluded that Mr Harris' medical care was equivalent to that he could have expected to receive in the community. However, Mr Harris should have moved to the substance misuse unit, but this was not possible because there was no space. He should also have had his blood pressure and pulse monitored prior to receiving doses of chlordiazepoxide. This was not done. The clinical lead for substance misuse said that if he had moved to the substance misuse unit, Mr Harris would also have seen a doctor again for a fuller assessment and would have been monitored at hourly intervals throughout the night.

68. The clinical reviewer concludes that:

“the delay in treatment and problems with location and monitoring appeared not to have had any obvious detrimental effects on his physical and mental well-being. He showed no signs of distress or agitation on the first night centre on the day prior to his death.”

69. The clinical reviewer recommends that prisoners who require detoxification treatment are transferred to the substance misuse unit where he would have been subject to closer supervision. We can only speculate whether this might have led to a different outcome for Mr Harris. This was an issue raised by the last HMIP inspection of Wormwood Scrubs. We concur with his recommendation that:

The Governor and Head of Healthcare should ensure that prisoners who require detoxification are transferred to the substance misuse unit.

Mental Health Referral

70. A month before he died, Mr Harris had told a nurse at HMP Pentonville that he suffered from anxiety and depression and had been prescribed antipsychotic medication in the community. However, Mr Harris did not disclose any mental health issues when he arrived at Wormwood Scrubs. Healthcare staff did not review his previous medical record and so, made no mental health referral. We concur with the clinical reviewer's recommendation that:

The Governor and Head of Healthcare should ensure that healthcare staff review a prisoner's medical record before assessing them.

Entering Mr Harris' cell

71. There was a period of around 1 minute 40 seconds between Officer A first looking through Mr Harris' observation panel and staff unlocking his cell door. Two officers arrived at Mr Harris' cell within a minute of the officer finding him and another three members of staff arrived just before the door was unlocked. He told the investigator he was deeply distressed and shocked by what he had seen. He said he knew that Mr Harris was already dead and he would have gone into the cell immediately on his own if he thought he could have helped Mr

Harris. The officer told the investigator that he would now feel more prepared to deal with such an incident and would enter a prisoner's cell immediately.

72. Staff responding to the emergency told the investigator that it seemed that they all got to Mr Harris' cell at the same time and there was no delay in unlocking the door. However, another officer said that she would not go into a cell alone, but would wait for one more member of staff. Another officer said that she understood that three members of staff should be present before unlocking a cell at night regardless of the situation.
73. Instructions about night procedures (PSI 24/2011, *Management and Security of Nights*), and about safer custody (PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from other (Safer Custody)*) are clear that preservation of life takes precedence over the usual arrangements for opening cells. At night, prison staff on wings do not carry standard keys but have a cell key in a sealed pouch for use in such an emergency. Where there appears to be immediate danger to life, prison staff can unlock cells by themselves without the authority of the night manager, subject to a personal risk assessment.
74. The clinical reviewer concludes that this delay would not have had an impact on the outcome for Mr Harris. Nevertheless, we are concerned that there was a delay before staff went into his cell. We make the following recommendation:

The Governor should ensure that staff open cells as soon as possible when there is an immediate danger to life.

Attempting resuscitation

75. According to nurses who responded to the emergency, Mr Harris' jaw was stiff but his limbs were not. The clinical reviewer concludes that, "on balance, attempting CPR in this situation might have been appropriate".
76. However, some of the nurses the investigator interviewed claimed that the existing policy was to attempt CPR irrespective of the state of the prisoner and even if there were clear signs that he had been dead for some time.
77. The European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...". The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be based on a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.
78. We have previously made recommendations to Wormwood Scrubs about this issue following deaths in 2013 and 2015. These were accepted. We repeat our previous recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

Staff and prisoner support

79. Staff interviewed by the investigator had had a mixed experience of the support they had received after Mr Harris' died. The prison did hold a debrief the morning of Mr Harris' death for all those involved in the emergency response. While some staff said that they felt adequately supported following this, others felt not. Some nurses who had not been involved in the emergency response but had assessed and had contact with Mr Harris earlier said that they would not know where to access support, nor had they been offered any. A further critical incident debrief should have been held five to ten days after Mr Harris' death to discuss the impact of his death and provide any support necessary. There is no record that the prison held a critical incident debrief.
80. Four prisoners who were employed on the first night centre said that, initially, no one spoke to them about Mr Harris' death. They worked out what had happened themselves and offered support to other prisoners located on the wing that morning. The day after Mr Harris' death, an officer spoke to these prisoners and offered her support, which they all appreciated. We do not believe it is acceptable these prisoners had to wait for 24 hours for this to occur and in the meantime were, themselves, offering support to other prisoners. We make the following recommendation:

The Governor should ensure a critical incident debrief is held after a potentially traumatic incident or death and staff and prisoners are offered appropriate and timely support.

Repatriation costs

81. The prison contributed to the cost of Mr Harris' funeral in line with prison service instructions but they did not offer to pay repatriation costs as indicated by PSI 64/2011. These costs were met by a charity after Mr Harris approached his local MP. The prison has not responded to repeated requests to find out why this was the case. We therefore make the following recommendation:

The Governor should ensure that the prison offers to pay reasonable repatriation costs following a death in custody.

**Prisons &
Probation**

Ombudsman
Independent Investigations