

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Harris a resident at Camden House Approved Premises on 7 August 2017

A report by the Prisons and Probation Ombudsman

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Wayne Harris died on 7 August 2017, from the toxic effect of taking a synthetic cannabinoid, at Camden House Approved Premises. He was 57 years old. We offer our condolences to Mr Harris' family and friends.

We are satisfied that staff at Camden House managed Mr Harris appropriately. However, we are concerned that a wellbeing check, conducted before his death was not sufficient to identify his condition at that time.

We are also concerned that the National Probation Service still does not have a mechanism in place to test residents for new psychoactive substance in their approved premises.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

Events

1. On 1 August 2006, Mr Wayne Harris was given an indeterminate sentence for public protection for possession of a firearm. On 23 June 2017, he was released from HMP High Down on licence to Hestia Streatham Approved Premises (AP). On 20 July, he was moved to Camden House AP.
2. Mr Harris had a history of alcohol and substance misuse. He completed drug and alcohol awareness work during his time in prison. On his release, there was nothing to indicate that Mr Harris still took drugs but alcohol remained an issue for him. As part of his risk management plan staff at Camden House tested Mr Harris for alcohol every day. There was no requirement to test him for drugs. Mr Harris drank daily, though not to excess. He told his key worker that alcohol helped him to cope and sleep. Mr Harris had a full-time job on a building site involving early morning starts and was generally always early to bed.
3. Mr Harris complied with the conditions of his licence and with the rules of the AP. He had a curfew from 11.00pm–6.00am, which was a standard curfew for all residents.
4. On Sunday 6 August, Mr Harris spent the lunchtime and early afternoon in a local pub with another resident. They returned to Camden House at about 3.30pm. Mr Harris was drunk and went straight to his room. At 7.00pm, a member of staff checked on Mr Harris and he was still asleep on his bed.
5. Just before 9.30pm, Mr Harris got up and left the premises. He came back approximately 20 minutes later. A member of staff tested Mr Harris for alcohol on his return. The test results were high but the member of staff was not concerned, as Mr Harris did not appear drunk. After the test was completed, Mr Harris went to his room.
6. At 11.44pm, a member of staff conducted a curfew and welfare check. Mr Harris was lying on his bed and the member of staff assumed that he was asleep.
7. Mr Harris was not up early the following morning. The same member of staff went up to his room to check on him at 8.20am. Mr Harris was lying on his bed in the same position; he was dead and appeared to have been so for some time. The member of staff did not attempt cardio pulmonary resuscitation as he considered it futile. He called the police and ambulance service and the AP manager.
8. Paramedics attended and confirmed that Mr Harris was dead. When the police arrived, they searched Mr Harris' room and found a small opened packet containing a small quantity of what they believed to be the drug 'Spice', a new psychoactive substance (previously referred to as a 'legal high'), and a half-smoked cigarette.
9. A post-mortem examination later confirmed that the most likely cause of Mr Harris' death was synthetic cannabinoid toxicity. He also had alcohol related fatty liver disease.

Findings

10. A member of staff at Camden House checked Mr Harris in his room shortly before midnight on the day before his death but could not confirm if Mr Harris was dead or alive at that time. He did not check Mr Harris thoroughly, despite knowing that he had been drinking heavily earlier in the day.
11. Mr Harris had a history of substance misuse but his issues were with alcohol. Staff at Camden House never tested Mr Harris for substance misuse because there was no requirement for them to do so.
12. We are concerned, in light of the prevalence of new psychoactive substances (NPS) in prisons, that the National Probation Service has not developed a strategy to deal with suspected NPS use in approved premises.

Recommendations

- The Approved Premises Manager at Camden House should ensure that checks made by staff on the wellbeing of residents are effective and sufficient to identify any issues or concerns.
- The National Probation Service should implement a strategy to reduce the supply and demand for NPS in Approved Premises including developing mechanisms to test for NPS use.

The Investigation Process

13. The investigator, issued notices to staff and residents at Camden House AP informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. He visited Camden House on 10 August. He obtained copies of relevant extracts from Mr Harris' probation records.
15. He interviewed three members of staff and a resident when he returned to Camden House on 25 August 2017.
16. We informed HM Coroner for Inner London North of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. The investigator wrote to Mr Harris' friend to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
18. We shared the initial report with the National Probation Service. There were no factual inaccuracies.

Background Information

Camden Approved Premises

19. Approved premises (APs) previously known as probation and bail hostels, accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and expected to register with a GP.
20. The National Probation Service manages Camden House AP. It has 42 bedrooms two of which are doubles. A key worker is allocated to each resident to oversee their progress and wellbeing and to help them adhere to licence conditions and the AP rules. Staff are on duty 24 hours a day to monitor residents' behaviour and report to their offender manager.

Previous deaths at Camden House

21. Mr Harris' death was the first recorded at Camden House.

New Psychoactive Substances (NPS)

22. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate and in APs. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. People under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence.
23. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers in prisons, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
24. APs do not currently test for NPS, which requires a urine sample, as they only have oral swab drug testing procedures in place. The National Probation Service says that this is because the nature of the buildings and staff make it impractical to implement urine testing across APs.
25. In a Learning Lessons Bulletin, published in November 2017, after Mr Harris' death, we raised concerns about the implications of NPS for the AP estate. We found deficiencies in information sharing about substance misuse by AP residents and in the effectiveness of welfare checks in APs. We identified the need for the National Probation Service to review its drug testing policy and to consider introducing testing for NPS and to give staff better guidance on NPS use.
26. Her Majesty's Prison and Probation Service (HMPPS) issued guidance on NPS to prisons and APs in August 2017 but it did not specify that APs should start testing for NPS. The National Probation Service accepted our recommendation

from a previous investigation in January 2017 that they should review drug testing arrangements in APs and take steps to enable staff to identify NPS use and advise residents of the dangers of using NPS.

27. There are currently no procedures in place at Camden House AP for NPS testing of residents.

Key Events

28. On 1 August 2006, Mr Wayne Harris was given an Indeterminate Sentence for Public Protection for possession of a firearm. He was released on licence in February 2012, but was recalled to prison in November 2016 and sent to HMP High Down.
29. On 23 June 2017, Mr Harris was released from High Down, on licence, to live at Hestia Streatham Approved Premises (AP). He met his Offender Manager, who discussed the conditions of his release with him. She spoke to him about the importance of not drinking heavily. Mr Harris had a history of alcohol and substance misuse and had completed drug and alcohol awareness work during his time in prison. There was nothing to indicate that Mr Harris still took drugs, but alcohol remained an issue for him. Regular alcohol testing was a requirement of his risk management plan but it did not include drug testing.
30. On 4 July, Mr Harris returned to Hestia Streatham smelling strongly of alcohol and unsteady on his feet. Staff tested him for alcohol and he admitted to drinking two bottles of wine. A member of staff spoke to him the next day. She advised him to attend alcohol addiction services. Mr Harris agreed, but later said there was nothing they could tell him that he did not already know.
31. On 20 July, Mr Harris was moved to Camden House AP following an allegation at Hestia Streatham that he had made threats to stab another resident. When Mr Harris arrived at Camden House, a residential assistant spoke to him and completed his initial induction. This involved familiarising him with the premises and highlighting rules, restrictions, expectations and health and safety issues. Mr Harris was given a single room and was subject to a standard curfew, meaning that he had to be on the premises between 11.00pm and 6.00am.
32. A residential assistant told Mr Harris that staff would test him daily for alcohol while he was at Camden House. Mr Harris initially objected to this but eventually co-operated with staff and complied with being tested for alcohol every day. Staff were not required to test him for drugs. During the induction, Mr Harris told him that he was not taking any medication.
33. On 26 July, Mr Harris had a meeting with his key worker. They discussed his drinking, which Mr Harris described as his way of coping with stress and helped him sleep. Mr Harris worked on a building site during the week as a slinger signaller (providing safe direction and supervision to crane operators). Mr Harris told him that he was drug and alcohol tested for his job. His key worker told Mr Harris that he should register with a local GP now that he had moved to Camden House but Mr Harris said that he did not want to. The key worker told the investigator that this was something he intended to discuss with Mr Harris again, once he had settled in.
34. On 2 August, his key worker met Mr Harris. They discussed his drinking and daily alcohol testing. Mr Harris complained that staff had objected to testing him very early in the evening. His key worker explained that they were exercising caution as residents often drank in their rooms after staff had tested them.

35. Mr Harris' alcohol testing indicated that he drank every day and more heavily at the weekend. The AP Manager, told the investigator that they did not set a maximum limit for residents' drinking but instead considered their behaviour and the risk they presented to themselves and others when they drank. Camden House staff recorded the level of Mr Harris' drinking each day and fed this back to his key worker and offender manager. Other than giving Mr Harris alcohol advice, staff did not take any further action.
36. On Sunday 6 August, Mr Harris left Camden House late in the morning. He did not sign out as required. He had arranged to meet another resident in a local pub for lunch.
37. Mr Harris and the other resident returned to the Camden House shortly after 3.30pm. Staff saw them on the CCTV but did not speak to them. They could see that Mr Harris appeared unsteady on his feet and the resident he was with had to help and support him. The resident collected the room keys and helped Mr Harris to his room. He later told the investigator that Mr Harris had been drinking heavily.
38. The resident left the premises but returned a few minutes later with some food, which he took to Mr Harris in his room. He did not see Mr Harris again.
39. Shortly after 7.00pm, a member of staff checked Mr Harris in his room. He said that Mr Harris was asleep on his bed and he could hear him snoring.
40. At 9.09pm, Mr Harris left his room to use the bathroom and returned shortly afterwards. At 9.24pm, Mr Harris left his room again, went downstairs and left the premises. He returned to Camden House at 9.47pm and a member of staff, asked him if he wanted to do his alcohol test. Mr Harris agreed, completed the test (result 74 micrograms of alcohol per 100 millilitres of breath – the legal limit for drivers is 35 micrograms), and returned to his room.
41. At 10.08pm, Mr Harris went into the kitchen and emptied his bin before going back to his room. At 10.18pm, he went back to the kitchen but returned to his room two minutes later.
42. At 11.45pm, a member of staff went to Mr Harris' room to conduct a curfew and wellbeing check. Mr Harris had left his door propped open with a shoe. He knocked on the door but Mr Harris did not respond. He pushed the shoe inside, entered the room and put a letter for Mr Harris on the floor. The room was in darkness but the TV was on and he could see Mr Harris lying on his bed with no clothes on. He said that he assumed that Mr Harris was asleep. He left the room and closed the door.
43. The member of staff returned to Mr Harris' room at about 8.20am the next morning. Mr Harris was normally up early to go to work and he said that he was surprised that he had not seen Mr Harris sooner. He knocked on Mr Harris' room door but when he did not get a response, he went inside. Mr Harris was lying on his bed in the same position that he had seen him in the night before. He said that the TV was still on and his shoes and the letter were in the same place.
44. He called Mr Harris' name but he did not respond. When he moved closer, he saw that Mr Harris was not breathing. He left the room but returned almost

immediately to check Mr Harris again. He said that Mr Harris' chest was not rising and falling and when he put his hand in front of his nose and mouth, he could not feel any breath. He also noticed that Mr Harris' skin was red where it was in contact with the mattress. He is first aid trained but did not attempt resuscitation, as he was satisfied that Mr Harris was dead.

45. He returned to his office and called the AP manager, the ambulance service and the police.
46. When the paramedics arrived, they confirmed that Mr Harris was dead.
47. The police arrived and searched Mr Harris' room. They found a small opened packet containing a small quantity of what they believed to be the drug 'Spice', a new psychoactive substance (previously referred to as a 'legal high'), and a half smoked cigarette. The police did not consider the death as suspicious and did not have the substance analysed.
48. The resident told the investigator that while he and Mr Harris were out on 6 August, Mr Harris told him that he enjoyed using Spice and asked him if he knew where he could get it. The member of staff did not believe that Mr Harris had any Spice at that time.

Contact with Harris' family

49. During his initial induction meeting at Camden House, Mr Harris told staff that he had no next of kin. He named a friend who he had recently met at Hestia Streatham AP as the person to contact in the event of an emergency.
50. After Mr Harris' death, the AP manager contacted her colleague at Hestia Streatham who told Mr Harris' friend that he had died.
51. She contacted Mr Harris' friend and offered her condolences. They remained in contact and the AP manager helped with the funeral arrangements.
52. Mr Harris' funeral was held on 10 October 2017. The National Probation Service contributed towards the cost in line with national guidance.

Support for prisoners and staff

53. After Mr Harris' death, the AP manager spoke to staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. She subsequently discussed the incident with other staff members. She reminded staff of the employer assistance programme. The area manager also spoke to staff on 8 August.
54. The AP manager held a meeting for residents on 9 August, where they discussed the circumstances of Mr Harris' death and staff offered support.

Post-mortem report

55. A post-mortem examination indicated the most likely cause of Mr Harris' death was from synthetic cannabinoid toxicity. He also had alcohol related fatty liver disease.

Findings

Wellbeing checks

56. Staff at Camden House AP undertake a number of curfew and wellbeing checks on residents throughout the day. AP guidelines say that these checks should involve a 'face to face interaction', with particular attention given to 'individuals with a risk of intentional self injury'.
57. A Camden House Area Manager, told the investigator that there is little difference between a wellbeing check and a curfew check. For each, staff must actually see the resident and make a basic assessment. Staff are expected to be more intrusive only if concerns about the resident are identified in their risk management plan, for example risk of suicide, self-harm etc. No such concerns were identified in Mr Harris' case.
58. Checks are conducted around 8.00am, 11.00am, 3.00pm, 7.00pm and 11.00pm. Between 11.00pm and 8.00am, a security guard carries out checks of the building but does not check on residents.
59. On 6 August, a member of staff checked on Mr Harris in his room at 11.45pm. He assumed that Mr Harris was asleep. He left the room and closed the door. When asked later by the investigator he could not say, with any degree of certainty, if Mr Harris was still alive at this time. He said that he was not concerned about Mr Harris, despite knowing that he had been drinking earlier that day. He had seen Mr Harris a couple of hours earlier to do his alcohol test, and had seen him on CCTV moving from his room to the kitchen. When he completed the morning check at 8.20am, Mr Harris did not respond when he tried to rouse him. When he checked further, it was evident that Mr Harris was dead.
60. A Camden House Area Manager told the investigator that Mr Harris' death raised concerns about the expectations of staff when residents who are being alcohol tested return a high reading. He suggested that, in future, consideration should be given to staff reporting the circumstances to an out of hours manager for advice. However, under the circumstances and under present guidelines' he considered that the member of staff's actions were 'reasonable'.
61. As our Learning Lessons Bulletin into deaths in Approved Premises finds, it is important that staff undertaking checks of residents satisfy themselves that the resident is safe and well, particularly if the resident concerned is known to have been drinking heavily.
62. While we cannot know if a more thorough check would have changed the outcome for Mr Harris, it could be vital in other cases. We make the following recommendation:

The Approved Premises Manager at Camden House should ensure that checks made by staff on the wellbeing of residents are effective and sufficient to identify any issues or concerns.

Substance Misuse

63. Our Learning Lessons Bulletin discusses the importance of effective testing of residents for drug use. The AP Manual says that testing known drug users on arrival, or when they are suspected of renewed substance misuse, is a targeted and prudent use of resources. It says that staff should have discretion to test residents if there is a reasonable suspicion of substance misuse, accepting this regime is a condition of living in APs.
64. Mr Harris had a history of substance misuse but there was nothing to suggest or indicate recent use. Alcohol remained a concern and he was tested regularly. It was not considered necessary to test Mr Harris for drugs and there is nothing recorded to indicate that the use of drugs was ever discussed with him.

NPS

65. Since September 2016, drug testing kits in prisons have been able to detect NPS from urine samples, and technologies are evolving all the time. The National Probation Service's analysis on NPS use in APs does not currently address the gaps in NPS testing. We recognise the National Probation Service's ongoing work to address the issue of NPS. However, the prevalence of NPS continues to make their omission from testing in APs a serious drawback in identifying patterns of usage and providing appropriate support and interventions.
66. Our Learning Lessons Bulletin discusses the challenge faced by Her Majesty's Prison and Probation Service in managing the risks posed by New Psychoactive Substances. It recommends that the National Probation Service revise the AP Manual to provide up to date guidance on the management of NPS use, review its drug testing policy within Approved Premises and consider introducing testing for NPS. We make the following recommendation:

The National Probation Service should implement a strategy to reduce the supply and demand for NPS in Approved Premises including developing mechanisms to test for NPS use.

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