CERTIFICATE OF FINDINGS

Section 94, Coroners Act 2006

IN THE MATTER of **Nicholas Ward HARRIS**

The Secretary, Ministry of Justice, Wellington

As the Coroner conducting the inquiry into the death of the deceased, after considering all the evidence admitted to date for its purposes, and in the light of the purposes stated in section 57 of the Coroners Act 2006, I make the following findings:

Full Name of deceased:	Nicholas Ward HARRIS
Late of:	Waikeria Prison Waikeria Road Te Awamutu
Occupation:	Prisoner
Sex:	Male
Date of Birth:	10 February 1974
Place of Death:	Waikeria Prison Waikeria Road Te Awamutu
Date of Death:	09 January 2011
Cause(s) of Death	
(a). Direct cause:	Asphyxia
(b). Antecedent cause (if known):	Unascertained (possible self strangulation / hanging and/or restraint asphyxia)
(c). Underlying condition (if known):	
(d). Other significant conditions contributing to death, but not related to disease or condition causing it (if known):	Morbid obesity with secondary dilated cardiomyopathy

Circumstances of death: Mr Harris died while being restrained in a prone position on the floor of his prison cell by a number of Corrections Officers. The officers had entered his cell due to a concern that Mr Harris may be attempting self-harm. When the officers attempted to apply approved control and restraint locks on Mr Harris, he resisted strenuously for approximately five minutes. At that point Mr Harris ceased struggling and was noted to be unresponsive. Medical assistance was immediately provided to Mr Harris but he could not be resuscitated.

I make, under section 57(3) of the Coroners Act 2006, the attached specified recommendations or comments that, in my opinion, may, if drawn to the public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

> I have considered whether I need to make a recommendation in relation to the failure by Master Control to inform the team of officers about to enter Mr Harris' cell of the fact that Mr Harris had slumped onto the floor. Having considered the evidence provided, I do not feel the need to make a recommendation. I believe that Waikeria Prison management will take on

board my comments on this issue and will give consideration to whether this issue needs to be addressed by way of staff training.

With any unnatural death that occurs in an institution, there are usually learnings which can be found through a close examination of the circumstances surrounding the death that relate to the systems or procedures of that institution. In this particular case, a comprehensive Inspectorate report has been completed, as well as this inquest with six days of evidence. I am confident that, if there are any other learnings to be gleaned by the Department of Corrections from this very unfortunate death, then that department will take cognizance of those learnings and will consider whether such systems or procedures can be improved.

Pursuant to section 74 of the Coroners Act 2006, I prohibit the making public of:

a. Any photographs taken of Mr Harris following his death; and

b. Any details of any of the Corrections Officers or nurses at Waikeria Prison who were directly involved in dealing with Mr Harris on 9 January 2011 that may lead to the identification of those officers or nurses

on the grounds that it is in the interests of justice, decency, public order, or personal privacy to do so.

Those findings, and my reasons for making them, are also set out in my written findings dated: 26 November 2012

Signed at Hamilton on 27th day of November 2012.

Coroner JP Ryan

IN THE CORONERS COURT
AT HAMILTON

CSU-2011-HAM-000020

UNDER	THE CORONERS ACT 2006
AND	
IN THE MATTER	of an Inquiry into the death of NICHOLAS WARD HARRIS

Date(s) of Hearing: 11 – 15, 18 June 2012

Appearances: P Morgan QC and E Staples, counsel assisting the Coroner
D Naden for the family of Mr Harris
J Foster, H Sims and T Lamb for Department of Corrections
Constable J Dixon for New Zealand Police

Date of Findings: 26 November 2012

RESERVED FINDINGS OF CORONER JP RYAN

INTRODUCTION

[1] Nicholas Ward Harris was a prisoner being held on remand at Waikeria Prison ("Waikeria") near Te Awamutu when he died on 9 January 2011.

[2] I decided pursuant to section 80(b) of the Coroners Act 2006 ("the Act") to hold an inquest for the purposes of this inquiry into the death of Mr Harris. The reason for that decision is that I wished to hear additional evidence in relation to this death in order to properly establish the matters required to be established under section 57(2) of the Act. In addition, Mr Harris died while in the custody of the Department of Corrections. As the death occurred in official custody or care, I am required pursuant to section 80(a) of the Act to hold an inquest for the purposes of this inquiry.

[3] The matters required to be established, so far as possible, under the Act are :

(a). That a person has died; and
(b). The person's identity; and
(c). When and where the person died; and
(d). The causes of the death; and
(e). The circumstances of the death.

[4] Therefore the purpose of this inquiry includes establishing, so far as possible, what happened to cause the death of Mr Harris, and why it happened. The Act specifically states that a Coroner does not open and conduct an inquiry to determine civil, criminal, or disciplinary liability.[1]

[5] The standard of proof applicable in this Court is the civil standard, the balance of probabilities. In determining any matters before me in this case, I have applied this standard in a flexible manner, in accordance with the view expressed by the Chief Justice, Dame Sian Elias, in *Z v Dental Complaints Assessment Committee.* In that case she refined the principle, established in earlier cases, that a *"trier of fact must be convinced by the evidence that the fact in issue is more likely than not. But the civil standard is flexibly applied because it accommodates serious allegations through the natural tendency to require stronger evidence before being satisfied to the balance of probabilities standard".*[2]

[6] At the inquest, evidence was heard from several Corrections Officers who currently work at Waikeria, and also from Department of Corrections senior management. Statements were also received from two nurses working at Waikeria, and who attended to

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[1] Section 57(1) Coroners Act 2006
[2] *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1

Mr Harris at the time of his death. The Corrections Officers, together with the two nurses, applied for complete anonymity. The ground for the application was that they all feared for their safety from prisoners at Waikeria, particularly as Mr Harris' family had published statements on the internet indicating that the family believed these Corrections Officers were directly responsible for Mr Harris' death. The application for anonymity was granted, to the intent that no details of these officers or nurses which could lead to their identification were to be mentioned in open Court. In addition, no such details were to appear on any documents produced in Court. The officers giving evidence, and the two nurses and other officers who provided written statements, were all given a specific designation which appears on the briefs of evidence and other statements produced in Court.

[7] An order was made, pursuant to section 74 of the Act, prohibiting publication of any details which could lead to the identification of any Corrections Officers and nurses who were dealing with Mr Harris around the time of his death on 9 January 2011. The order was made on the basis that I am satisfied it is in the interests of justice, public order and personal privacy to make such an order. In particular, I recognise that Corrections Officers and nurses are constantly at risk of violence from prisoners and that, in this case, such risk is likely to be elevated by the comments published on the internet. In addition to this, Mr Harris was a member of the Black Power gang. I consider that his gang membership heightens the risk of violence against Corrections Officers even further, as fellow members of that gang incarcerated in Waikeria may wish to seek retribution for Mr Harris' death.

FACTS

[8] Mr Harris was thirty-six years of age, 175 centimetres tall and weighed 192 kilogrammes. He was clinically morbidly obese, and had a family history of heart disease. He was known to suffer from asthma and was a smoker.

[9] On 28 December 2010, Mr Harris was arrested for wilful damage during a domestic violence incident. He was bailed the next day. On 29 December, Mr Harris was arrested again and held in Police custody until 3 January 2011 when he was subsequently bailed. He was again arrested the same day for theft, and on the following day for threatening behaviour against Police and resisting arrest. On 5 January 2011, Mr Harris appeared in the Hamilton District Court and was bailed. He was arrested later that day in Hamilton for theft, and remanded in custody for a bail hearing on 7 January. While in Police custody in the Hamilton District Court and the Hamilton Police cells on 5 and 6 January, Mr Harris broke three cell windows. He also abused staff, threatened them and was disruptive. His behaviour was abusive and aggressive.

[10] On 6 January 2011 at approximately 7:00 pm he was received at Waikeria Prison. He continued to display aggressive behaviour towards staff, and following an assessment of his at-risk status, he was placed in the Kotuku Unit. The next day Mr Harris was transported back to the Hamilton District Court for a further appearance. He was remanded in custody until 21 January, and returned to Waikeria at approximately 11:00 am. Mr Harris was again aggressive towards staff on reception and challenged one officer to a fight. He was again assessed to be at risk and consequently placed in the Kotuku Unit.

[11] Later that day, the Principal Corrections Officer ("PCO") for the unit reassessed his at-risk status and decided that Mr Harris was no longer at risk of self-harm. Mr Harris was therefore transferred to the Remand Unit. Overnight, his behaviour disturbed other prisoners in the unit as he was yelling abuse and slamming his cell window flap open and shut. The next morning he displayed aggression towards staff and threatened to 'take staff on'. Later that day, prison staff noticed that Mr Harris had completely removed the cell window from its position and had placed it on the floor. At approximately midday, the Custodial Systems Manager ("CSM") approved an application for initial segregation under section 58 (1)(a) of the Corrections Act 2004.

[12] Mr Harris was moved to a different cell in the Remand Unit due to the damage he had caused to the previous cell. In his new cell, he covered his cell window and refused staff instructions to uncover the window. At around 3:00 pm he flooded his new cell and attempted to damage the cell door window. The on-call CSM therefore approved the PCO's request to place Mr Harris in the Separates Area. He was then relocated to the Separates Area and placed in cell 10.

[13] The next morning, 9 January 2011, when staff asked Mr Harris to put his breakfast tray outside the cell, he kicked the tray towards the door instead. When asked to hand over the bowl and eating utensils which were in the cell, Mr Harris told the officers to come and get them. He was observed rubbing one of the eating utensils against the concrete and indicated to the officers that he had a 'shank'[3]. It was noted that he had also broken the Perspex observation window of the cell door into two parts. As a result of this threatening behaviour and damage to the cell, the on-call CSM and the PCO decided to relocate Mr Harris to another cell.

[14] Cell 10 in the Separates Area ("cell 10") had a closed-circuit TV camera ("CCTV") installed, and this enabled staff in the Master Control room ("Master Control") and other parts of the prison to observe what was happening in the cell. At approximately 11:05 am on 9 January 2011, a staff member in Master Control issued a 'Code Blue'[4] call over the prison

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[3] A term commonly used by prisoners to refer to a weapon.

[4] An alarm call requiring Incident Response Officers ("IROs") to attend immediately.

radio system. This was because Mr Harris had been observed via the cell camera to be making a noose with a sheet and placing it around his neck. At the same time, a Control and Restraint ("C & R") team had been assembled for a briefing in the PCO's office for a planned 'control and restraint' relocation of Mr Harris to another cell.

[15] On arrival at cell 10, the IROs found Mr Harris walking around in his cell. On instructions from the PCO, staff did not enter the cell. A Senior Corrections Officer ("SCO") engaged Mr Harris in conversation, which became a mixture of lucid dialogue and verbal abuse by Mr Harris. The conversation continued for several minutes and the SCO managed to talk Mr Harris into handing over strips of torn sheet, blanket and a noose. The SCO left the Separates Area to speak with the on-call CSM, and staff were instructed to remain outside the cell unless Mr Harris was harming himself.

[16] At approximately 11:40 am, a second 'Code Blue' was issued by Master Control in response to actions observed via the cell camera. The officers outside the door of cell 10 tried to observe Mr Harris in the cell through the cell door window, but were only able to sight his legs. He appeared to be sitting down behind the door. Master Control had observed Mr Harris slump to his left hand side onto the floor. The IROs entered the cell, initially with some difficulty as Mr Harris was effectively lying across the doorway. Six officers entered the cell, and immediately attempted to apply control and restraint techniques on Mr Harris as he lay face down on the cell floor. Mr Harris violently resisted the application of these holds, and additional officers were called to assist. After a struggle lasting approximately five minutes, the officers were able to restrain Mr Harris and handcuffs were applied to his wrists behind his back. At around this point, Mr Harris stopped struggling.

[17] Immediately after Mr Harris was secured, a registered nurse standing outside the cell was asked to check on his breathing. This nurse could not detect any signs that Mr Harris was breathing, and an ambulance was immediately called. Staff removed the handcuffs. Mr Harris was rolled onto his side, and a second registered nurse immediately applied an oxygen mask to his face. Cardiopulmonary resuscitation was also commenced, a defibrillator was attached to Mr Harris but did not indicate any shockable rhythm. Mr Harris could not be resuscitated.

ISSUES

[18] There are a number of issues to be considered in this inquiry.

Issue 1: The assessment of Mr Harris' at-risk status upon reception at Waikeria on 7 January 2011 and subsequent custodial management

[19] The Department of Corrections ("DoC") is the government department responsible for the operation of our prison system. As is to be expected, there is a comprehensive set of guidelines governing, inter alia, the treatment of prisoners. This set of guidelines is known as the Prison Service Operations Manual ("PSOM").

[20] As a result of Mr Harris' death, an investigation was carried out by Niuia Aumua, Inspector of Corrections, and an extensive and comprehensive report ("the Inspectorate report") provided to the Chief Executive of DoC. The terms of reference for this Inspectorate report were to investigate and report on the circumstances surrounding the death of Mr Harris, particularly in regards to whether the standards, procedures, operational systems, work practices and internal controls were being complied with. Coupled with this is the ability for the Inspector to make recommendations for such improvement to the procedures as may be necessary, arising out of the investigation.

[21] The Inspector found that the assessment of Mr Harris' at-risk status on 7 January 2011 fell short of the national requirement. In particular, the PCO and the nurse who consulted on that assessment, did not make enquiries relating to Mr Harris' mental state concern from the night before. In addition, the report found that there was no evidence to suggest an Immediate Needs assessment was completed. The Inspectorate report states:

> *"Given Mr Harris' highly elevated behaviour when he was received from Court on the 6 and 7 January 2011, an Induction interview and Immediate Needs assessment would have been necessary. Apart from the 'At Risk' and 'Health Reception Triage' assessments of Mr Harris, there had not been any other recorded staff interaction with Mr Harris to find out why he had been acting in a highly aggressive manner."* [5]

[22] If the assessment on 7 January 2011 had found Mr Harris to be at risk of self-harm, then he would have remained in the Kotuku Unit. Debra Gell, the Clinical Director for the Prisons Service group, gave evidence that the management of Mr Harris, if he had remained in the Kotuku Unit, would have depended on how he presented. It became clear that Mr Harris' mental health record had not been obtained by the prison health service, but the logistical difficulty in doing so within the time frame of this incident made this impractical. Notwithstanding this, in my view it is best practice for prior mental health records to be obtained as soon as possible to assist in understanding a prisoner's particular history and current mental health state. No direct evidence was provided to show that Mr Harris' death could have been avoided if he had remained in the Kotuku Unit, as this is purely a matter for

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[5] *Report to Chief Executive, Department of Corrections,* Niuia Aumua, Inspector of Corrections, para 158

speculation. Nevertheless, this finding by the Inspector is a matter that was properly brought to the attention of DoC.

[23] A clinical review of the prison health services was undertaken following Mr Harris' death. The review made six recommendations in relation to documentation and communication between forensic mental health services and prison health services, the involvement of prison health services in the at-risk process, and documentation and communication between prison health services and custodial staff. Ms Gell states in her evidence that all of these recommendations have been implemented.

Conclusions

[24] I accept the finding in the Inspectorate report referred to above. I also accept that the recommendations made by the Inspector in relation to this particular finding, and the recommendations contained in the review of the prison health services, have been implemented by the Department of Corrections. I am satisfied that the implementation of these recommendations will assist in reducing the possibility of such failings occurring again in the future. Accordingly, there is no further comment or recommendation required from me to address these matters.

Issue 2: Response to the first 'Code Blue'

[25] Prior to 11:00 am on 9 January 2011, Mr Harris was observed on the CCTV to be walking around his cell in a somewhat agitated state. He was ripping up items of bedding and at one point was observed to make a noose from a strip of sheet and put the noose around his neck. At 11:05 am, Master Control issued a 'Code Blue' call. IROs immediately attended at cell 10, in accordance with prison protocols. Staff did not enter the cell, as they were instructed not to enter unless it was obvious that Mr Harris was attempting to self-harm.

[26] As stated above, this situation was defused by the SCO engaging Mr Harris in conversation. As a result, Mr Harris handed over some of the items he had ripped up, including a sheet that he had fashioned into a noose. The officers remained outside the door of cell 10, periodically monitoring Mr Harris by looking through the cell window. Staff were aware that a C & R team was being assembled to relocate Mr Harris; hence they were simply maintaining a watch on cell 10. During this time, Mr Harris was communicating with the officers from time to time. Corrections Officer ("CO") 6 states that Mr Harris was threatening to harm anyone who entered the cell.

Conclusions

[27] The response by the IROs to the first 'Code Blue' was appropriate and adequate. Communication was being maintained with Mr Harris, and periodic visual sightings were maintained. In addition, staff outside the cell were aware that the cell CCTV camera enabled Master Control to monitor Mr Harris' actions within the cell. It was established that, at that particular point in time, Mr Harris was in no immediate danger or distress. Therefore, there was no need for staff to enter the cell at that time.

Issue 3: Response to the second 'Code Blue'

[28] When the first 'Code Blue' was called, the C & R Team was in the midst of a briefing in the PCO's office. Their task was to relocate Mr Harris to a different cell. Given Mr Harris' history of aggressive behaviour towards staff, his large size and considerable strength, plans were being formulated to include the potential use of pepper spray. This briefing was being videotaped by PCO 2, and the tape recording has been made available to this Court. The use of pepper spray had only recently been allowed, and only staff trained in its use and using personal safety gear were allowed to deploy the spray.

[29] After the SCO had engaged with Mr Harris following the first 'Code Blue', the SCO left the area to ensure that staff in the South Wing were able to monitor Mr Harris on the CCTV. Instructions were given that staff outside cell 10 were not to enter the cell unless it became obvious that Mr Harris was attempting to self-harm. While the SCO was away from cell 10, there was not a great deal of dialogue between other staff outside the cell and Mr Harris. SCO 2, positioned outside the cell door, heard Mr Harris threaten to hang himself. Approximately three minutes later, SCO 2 kicked the cell door and called out to Mr Harris. The CCTV footage shows Mr Harris standing up against the cell door, and then slide down the door and sit on the floor with his legs outstretched in front of him. Another officer looked through the observation window and reported that he could see Mr Harris down against the door.

[30] At around the same time, CO 9 in Master Control observed Mr Harris sitting against the cell door, then place a hand around his neck, and lift the other hand in the air. At that point, Master Control issued a second 'Code Blue'. This call included reference to a "possible hanging." Mr Harris then slumped forward and to his left, ending up lying on the floor, partially across the doorway. SCO 1 arrived outside cell 10 very quickly after this call, and made the decision that staff would need to enter the cell.

[31] The officers experienced some initial difficulty in opening the door, as Mr Harris was lying on the floor partially behind the door. Three or four officers pushed the door open and

were able to enter the cell. Mr Harris was lying face-down on the cell floor, between the doorway and the toilet which was to the left of the doorway as you enter the cell. SCO 1 remained outside the cell, and noted that the officers in the cell were struggling with Mr Harris. He informs that the officers were using approved control and restraint techniques, but that Mr Harris was resisting violently and struggling with the officers.

[32] Additional staff were called for, and these new arrivals relieved officers in the cell who were exhausted by the struggle. Once the officers had control of Mr Harris, and he had stopped resisting, handcuffs were applied. At this point, Mr Harris was moved back from the cell wall and away from the toilet, to improve the air flow around his face. The two registered nurses standing outside the cell then checked his breathing. When they noted that Mr Harris was unresponsive, an ambulance was called for and CPR commenced. The defibrillator pads were applied, but the machine indicated there was no shockable rhythm detected. CPR continued, and again the defibrillator was checked, but with the same result. A third cycle of CPR was commenced, and again the defibrillator was asked to deliver a shock, but indicated for a third time that there was no shockable rhythm detected. The two nurses then made the clinical decision to stop all CPR, as Mr Harris had died.

[33] Family have made submissions that the officers did not need to enter the cell following the second 'Code Blue', as they consider that Mr Harris was not attempting self-harm. In their view, Mr Harris' death could have been avoided if the officers had simply remained outside the cell and waited for the arrival of the C & R Team which was being briefed to relocate Mr Harris. They believe that Mr Harris would not have resisted this team, and therefore there would not have been a struggle and the resultant death.

[34] SCO 1 stated in his evidence that it is standard practice to issue a 'Code Blue' if there is a possibility of a self-harm incident by a prisoner. When SCO 1 arrived outside cell 10, he made the decision that staff needed to enter the cell because he was concerned with the possibility that Mr Harris was self-harming. This decision was made in the background of Mr Harris' aggressive and irrational behaviour, and on his history that morning when he had been observed with a noose around his neck. In addition to this, one officer outside cell 10 heard Mr Harris threaten to hang himself, and this officer was unable to obtain a response from Mr Harris by kicking the door.

[35] There was a short delay from the time the second 'Code Blue' was called until the Corrections Officers entered the cell. It was during this time that Master Control observed Mr Harris slump to his left onto the floor. Given that this is a significant event, I consider this to be information that the officers about to enter the cell would want to have. This information was not passed on to the officers, and so they were not aware that Mr Harris had slumped to the floor.

[36] Evidence was given on this point by Wayne Le Haavre, the National Coordinator for Control and Restraint and Advanced Control and Restraint, for the Department of Corrections. His opinion is that the officers had all the information they needed when they entered the cell. He stressed the urgency of the situation, and also implied that it was not critical for the officers to know whether Mr Harris was still self-harming. However, he then conceded that knowing whether or not Mr Harris was self-harming would have been good information for the officers to have had. SCO 1 gave evidence that he did not consider it was necessary to contact Master Control for an update on the status of Mr Harris just prior to entering the cell. In his view, urgency was required because of the possibility Mr Harris was self-harming.

[37] Counsel for the Department of Corrections made submissions that the fact Mr Harris had slumped to the floor was not information that should have been passed to the officers because it was not necessary for them to know this, and knowing it would not have affected the actions of the officers upon entering the cell. I accept that the officers were aware, prior to entering the cell, that Mr Harris was on the floor somewhere near the door. They knew this because they could not see him standing anywhere else in the cell. Nevertheless, if I was an officer about to enter a cell for a control and restraint procedure, I would want to know the location and status of the prisoner in that cell just prior to entry.

Conclusions

[38] I am satisfied on the evidence that the decision by SCO 1 that officers enter Mr Harris' cell was appropriate and necessary under the circumstances. The decision was made on the basis that urgent intervention was needed to ensure Mr Harris' safety and well-being. Master Control observed actions which indicated the possibility of self-harm, and then had difficulty sighting Mr Harris. Officers outside the cell could not get Mr Harris to respond; they could only see Mr Harris' legs through the window, and he appeared to be lying down in front of the door.

[39] If officers had failed to check on Mr Harris, and he had been suffering a medical event or the effects of a self-harm attempt, then I would consider the officers' lack of response to be a dereliction of duty. No doubt family would also have been severely critical of staff if they had failed to check on Mr Harris and it was later found that he had self-harmed or suffered a medical event and required treatment.

[40] In my view it would have been good practice for Master Control, having observed Mr Harris slump to the floor of the cell, to have reported this unexpected event to the officers outside cell 10. Master Control was clearly aware that the officers had not yet entered the cell by virtue of observing the CCTV footage. Regardless of whether such a report would have made any difference to the actions of those officers, I consider that officers about to enter a cell to carry out a spontaneous control and restraint of a prisoner in response to a

concern of self-harm (or indeed for any reason) should have the most up-to-date information on the status of the prisoner in the cell prior to affecting entry.

Issue 4: The Control and Restraint of Mr Harris in Cell 10

[41] When the officers entered cell 10, Mr Harris was lying face down on the floor of the cell. At least five, and possibly six, officers entered the cell at that time. Officers immediately moved to the appropriate control and restraint positions – one to the head, others to the arms and the legs. Normally only one officer would assume these positions, but because of the numbers of staff available, and the size and strength of Mr Harris, more officers became involved in applying restraints to his arms and legs. At this point, the evidence of the officers involved is that Mr Harris was struggling violently from the time that the officers first took up their positions. The officers on Mr Harris' arms were attempting to apply an approved restraint hold which involved his hands being held behind his back and up towards his shoulder blades. The officers on his legs were working on an approved restraint hold which involved his legs being bent upwards so that his ankles were crossed and held against his buttocks.

[42] The struggle to control and restrain Mr Harris lasted for at least five minutes. During this time, more staff were required to assist as some of the officers had become exhausted. Eventually, Mr Harris stopped struggling and officers were able to apply handcuffs. By this time, his legs were also in the approved restraint hold. All of the officers who gave evidence were consistent that Mr Harris was struggling violently during this five minute period.

Control and Restraint Guidelines

[43] When questioned on whether a plan was formulated prior to entering the cell as to what officers were to do once entry had been gained, SCO 1 stated that, although a plan would normally be formulated, when faced with an emergency response then the plan is simply to go in and control and restrain the prisoner. This is what happened in this case. In a normal situation, once a prisoner has been restrained, the officers involved can then assess the prisoner's state of health.

[44] What was abnormal about this case is that Mr Harris resisted as the officers tried to restrain him. As a result, the process took some time and involved a significant number of officers in a very confined space. If Mr Harris had not struggled with the officers when they first took up their C & R positions, then they could have assessed his medical condition much sooner. If Mr Harris had indicated to staff that he was unwell or distressed, then no doubt medical attention would have been given to him immediately.

[45] In his evidence, Mr Le Haavre states that C & R situations are either planned or spontaneous, and that there is a significant difference between the two. With a planned C & R, officers have a briefing before the event and are provided with protective clothing and armed with shields and possibly pepper spray. Officers required to respond spontaneously do not have the luxury of a briefing or such protective clothing or equipment. Nevertheless, officers are trained to act appropriately in a spontaneous C & R situation.

[46] At the inquest, Mr Le Haavre was asked whether the officers entering the cell considered employing non-physical intervention. His response was that, once the decision to enter the cell had been made, there was no opportunity to 'stop and think' as the officers had to respond quickly to contain the incident. He also stated that, in this particular incident, there was no reason to stop and assess what the officers were confronted with immediately upon opening the cell door. He states that the appropriate course of action was to go into the cell and restrain Mr Harris, and that the restraining of Mr Harris was not designed to harm him but rather to ensure his safety.

[47] Mr Le Haavre acknowledges the risk of asphyxiation when a prisoner is being restrained, particularly while lying face down. He states that staff are trained to recognise and mitigate the risk. Mitigation involves ensuring that the person is not lying face down for any longer than he needs to be, and that officers try to raise the person's chest from the floor using a foot or a knee under the person's shoulder. When questioned on this, Mr Le Haavre states that he considers the mitigation techniques were employed by the officers dealing with Mr Harris. This is supported by the evidence of some of those officers who indicated the measures they took to try to relieve pressure on Mr Harris' chest during the restraint procedure. In addition, evidence was given that as soon as Mr Harris stopped struggling and the handcuffs had been applied, he was rolled over onto his side. Mr Le Haavre states categorically that, in his opinion, Mr Harris was not held face down any longer than was necessary for the officers to gain control. Mr Le Haavre gave his opinion that the control and restraint exercise carried out on Mr Harris was in accordance with the training and guidelines for such procedures.

Application of Body Weight

[48] Mr Le Haavre states that during a C & R procedure, officers may apply body weight simply to bring a person to the ground; body weight is not applied while a person is on the ground to try to subdue the person. However, it is possible that during a struggle with the person on the ground, body weight may be applied during the attempt to control and restrain the person. If so, this would only be momentary rather than sustained. In this particular case, Mr Le Haavre states that he did not consider that there was body weight being applied to Mr Harris for any sustained period of time. He concedes that it may appear that there is a

lot of weight being applied to the back of a person being restrained on the ground, but he states that the locks and holds are designed to take pressure off the back.

[49] SCO 4 gave evidence that he was standing on his feet while bending over Mr Harris when he took up his position beside the head. He states specifically that he was not applying his body weight to Mr Harris' back, and that he was simply holding his head down with his hand. He also states that other officers were not leaning on him, thereby inadvertently causing body weight to be applied to Mr Harris' back. However, he does acknowledge that, as the struggle grew progressively more serious, he may have applied his weight to Mr Harris' back. He goes on to state that he would have removed the weight as soon as he realised that he had applied it.

[50] Other officers also gave evidence indicating that, at various times, they were required to apply some of their body weight to hold Mr Harris down during the restraint process. From the evidence provided, it appears that the application of the body weight by each of the officers was controlled and momentary. What is not clear is the cumulative effect of the different officers applying their body weight, even if at different times, on Mr Harris' ability to breathe.

Number of Officers involved in Restraint

[51] Another concern is the number of officers in the cell and involved in the restraint of Mr Harris. SCO 4 states that he was not concerned about this because there were only four or five officers that had hands on Mr Harris at any one time. He states that this number was not excessive, given the size and strength of Mr Harris. The CCTV footage shows that other officers were standing around at the back of the cell, either having been relieved by fresh officers, or simply acting as backup should they be needed. Mr Le Haavre states that these officers became trapped at the back of the cell, being unable to exit the cell due to the position of Mr Harris on the floor and the officers around him trying to restrain him.

[52] When the officers entered cell 10, they were faced with an elevated level of risk of harm from Mr Harris. He had a history of aggressive, abusive and threatening behaviour, and had been observed sharpening a plastic eating utensil earlier that day. Given his size and strength, and his belligerent attitude, the level of risk they faced was, in my view, very high. The officers' first response upon entering the cell was to control and restrain Mr Harris, in accordance with their training and with prison protocols. This was achieved in accordance with the approved control and restraint methods.

Resistance by Mr Harris

[53] The family are of the view that Mr Harris was not resisting the officers when they entered the cell and attempted to restrain him. In their opinion, Mr Harris was fighting for his

life – not against the officers, but because he suddenly found himself struggling to breathe. I have considered this scenario, and while it is plausible, the length of the struggle by Mr Harris causes me to doubt that this is what occurred. If Mr Harris had suddenly found himself struggling to breathe to the point where he collapsed on the floor, in my view it is more likely that he would indicate his distress to any person near him rather than struggle violently, which would consume more oxygen. Although Mr Harris' initial reaction to the officers entering the cell may have been to resist them, if he was struggling to breathe then I consider it more likely that he would stop struggling as soon as he appreciated the seriousness of his breathing difficulty. This is likely to be much less than five minutes.

[54] From the outset of the restraint, SCO 4 who was at Mr Harris' head, can be heard on the video tape talking to Mr Harris and attempting to reason with him. SCO 4 was perfectly positioned to be able to hear any call for help from Mr Harris. His evidence, and the evidence of the other officers in the cell, is that Mr Harris did not give a verbal response, and did not give any indication that he was in distress. Only Mr Harris knows why he did not ask for help, and why he continued to struggle.

[55] The question of whether or not Mr Harris may have been suffering a seizure rather than resisting was considered. Officers involved in the restraint were asked whether they considered Mr Harris was suffering a seizure. Several of the officers gave evidence that they had experience of prisoners suffering seizures in the past, and in their opinion, Mr Harris did not appear to be suffering a seizure. In particular, they stated that in their experience, people suffering seizures tend to stiffen their limbs rather than thrash about as Mr Harris was.

[56] Dr Stables, the pathologist who performed the post-mortem examination of Mr Harris, has alluded to the fact that Mr Harris may have been suffering a seizure. He notes that a seizure could be brought on by a lack of oxygen to the brain and that this could be caused by a ligature. However, he states that he is unable to determine from the statements he perused and from the post-mortem examination whether or not Mr Harris did suffer a seizure. Officers involved in the control and restraint of Mr Harris gave evidence that they were familiar with prisoners having seizures. They were all of the view that the struggle by Mr Harris was not consistent with their experiences of prisoners having seizures. While I accept that this evidence is not scientifically conclusive, I consider the consensus of views does establish on the balance of probabilities that Mr Harris was not having a seizure.

[57] I have also considered the possibility that Mr Harris acted out a collapse with the intent of enticing the officers to enter the cell so that he could fight with them. Evidence was given that Mr Harris had previously taunted the officers, indicating that he wanted to fight with them and inviting them to enter the cell. He had also been observed sharpening a

plastic eating utensil against the wall of the cell, but he had handed out all of the utensils prior to the officers entering the cell.

[58] Two factors have caused me to discount this as being a plausible scenario. First, Mr Harris could have chosen any point within the cell to stage such a collapse. I consider it unlikely that he would choose to collapse on the floor with his face beside the toilet. Second, he collapsed behind the cell door, effectively blocking it from being opened. If his intent was to entice the officers into the cell, then why would he make it difficult for them?

Family Concerns

[59] The family of Mr Harris have also raised the possibility that pepper spray was used against Mr Harris, and that this has contributed to the asphyxia which caused his death. The use of pepper spray was authorised under certain circumstances and if deployed by trained Corrections Officers. The C & R team that was in the middle of a briefing when the second 'Code Blue' was called were anticipating the possible use of pepper spray. As it turned out, the control and restraint of Mr Harris took place without the involvement of the C & R team. The Corrections Officers and prison management specifically stated in their evidence that pepper spray was not used against Mr Harris at any time while he was at Waikeria. It is also obvious from viewing the CCTV footage that Mr Harris was not subject to the application of pepper spray. If he had been, there would have been clear evidence by his reaction; there would also have been reaction from officers in the cell from the residue of the spray.

[60] Family have also expressed concern that Mr Harris was subject to a blow from a baton, administered through the window of his cell door. Again the CCTV footage does not show such an assault occurring. Family base this concern on the appearance of Mr Harris when they viewed him after his death. They are of the view that his nose was broken, and that this was done by a Corrections Officer using his baton through the cell door window. In my view, if this had occurred, although the CCTV footage would not necessarily show the actions of an officer poking his baton through the cell window, it would certainly have recorded Mr Harris' reaction. In my viewing of the footage I could not detect any action by Mr Harris indicative of him reacting to a baton being slammed into his face. I note also that the pathologist's report makes no mention of an injury to Mr Harris' nose.

Conclusions

[61] I am satisfied from the evidence provided to me that the actions of the officers involved in the control and restraint of Mr Harris on 9 January 2011 were appropriate and reasonable. I acknowledge that the evidence of the officers involved may be seen to be self-serving, to deflect any criticism of their actions. Notwithstanding this, I found that the witnesses were not evasive under questioning and I have no reason to doubt their integrity.

Their evidence was largely consistent with regard to the carrying out of the control and restraint procedure and the ensuing struggle by Mr Harris.

[62] I have also had the benefit of viewing the CCTV footage and the video recording made by PCO 2. The CCTV footage shows what I would describe as a seething mass of humanity in cell 10 during the control and restraint of Mr Harris. Although Mr Harris cannot be seen in the footage due to the number of prison officers swarming around him, it is clear that the officers are engaged in a real struggle. This is evidenced by the constant movement of the officers shown on the CCTV footage and their laboured breathing heard on the audio recording from PCO 2's video camera. The footage does not show any actions by any of the officers involved that I would consider to be an excessive or gratuitous use of force. The actions of the officers appear to be controlled and restrained, and no more than was necessary to apply the approved locks to a prisoner who was strenuously resisting.

[63] I accept the evidence of the officers, which was supported to some extent by the CCTV footage and the audio recording from the hand-held video camera, that some measures were taken to mitigate the risk of restraint asphyxia. Officers involved in the control and restraint of Mr Harris were clearly aware of the risks of restraint asphyxia, and SCO 4 in particular attempted to raise Mr Harris' shoulder to alleviate the pressure on his chest during the struggle. I note also that, as soon as Mr Harris ceased to struggle, his airway was checked and the prison nurses were at his side. I do not accept the submission made by counsel for the Harris family that SCO 4 was lying across the back of Mr Harris. Although the CCTV footage is difficult to interpret clearly, my viewing of the footage does not lead me to believe that SCO 4, or any other officer, was applying their body weight to Mr Harris' back for any extended period of time.

[64] I acknowledge that the officers gave evidence that they did apply some body weight to the back of Mr Harris from time to time, but I accept their evidence that any application of body weight would have been momentary. I also accept that such application of body weight is an acceptable technique for the control and restraint of a resisting prisoner under certain circumstances. In the circumstances of the case before me, I accept that it was reasonable and even necessary due to the strong and continued resistance by Mr Harris to the officers' attempts to restrain him.

[65] Having said that, I also consider that the application of body weight by the Corrections Officers during the restraint of Mr Harris was a factor which contributed to the asphyxia that resulted in his death. This conclusion is based on the evidence provided by Dr Stables that weight placed on a person's back while they are lying prone will affect their ability to breathe. In Mr Harris' case, his ability to breathe was already compromised by

virtue of the fact that he was morbidly obese and lying prone. Any application of weight to his back would, in my view, further compromise his respiratory function.

[66] I am satisfied from the evidence before me that Mr Harris was not subjected to the use of pepper spray at Waikeria on 9 January 2011. I am also satisfied that there is no evidence suggesting Mr Harris was struck by a baton thrust through the cell window on that day. I consider that what family believe to be an injury to his nose is likely to just be post-mortem artefact.

Issue 5: How and why did Mr Harris die

[67] Mr Harris died from asphyxia. Dr Stables is unable to state with any significant degree of certainty the cause of the asphyxia. He states that it is possible the asphyxiation was caused by the ligature that Mr Harris had around his neck, even though there was no compelling physical evidence of this. However, he states that a very soft ligature may not leave a great deal of physical evidence and therefore he cannot rule out this possibility.

[68] Dr Stables also cannot rule out the restraint of Mr Harris as the reason for the asphyxiation. He states that it is well documented that people have died while being restrained on the ground, but the actual cause of the death and why the death occurs is debated and not clearly ascertained. He states that in many cases there is underlying disease or the use of drugs, both of which are likely to be contributing factors to the death. In the case of Mr Harris, the toxicology report reveals that the use of drugs was not a contributing factor in his death. But Mr Harris had some significant health issues: he was morbidly obese, he had a massively enlarged heart, and he suffered from asthma. In his post-mortem report, Dr Stables notes that the condition of Mr Harris' heart was such that he could have died at any time. I take this to mean that he could have died without any catalyst such as oxygen deprivation or the stress of being physically restrained.

[69] I accept that physical restraint by a number of Corrections Officers on a person of Mr Harris' temperament and attitude towards authority is likely to have caused him a significant degree of stress. Given the delicate state of Mr Harris' heart, such stress could have proved fatal. In addition, his morbid obesity is likely to have made him more susceptible to the danger of asphyxiation while being restrained. Notwithstanding this, as stated above, it was necessary for the officers to enter the cell for the reasons stated above. Having entered the cell, it was then necessary for the officers to employ the control and restraint locks on Mr Harris because of the climate of intimidation and aggression that he had created by his behaviour towards other prisoners and overt threats against staff.

[70] Mr Harris may have been suffering some form of medical event when he was observed to slump over to his left and end up lying on the floor of his cell. This event may have been triggered by Mr Harris pulling on the ligature around his neck, or it may have been due to his underlying medical condition. I accept that it is possible that Mr Harris pulled the ligature tight around his neck briefly while sitting on the floor behind the cell door, and suffered a temporary restriction of blood flow to the brain sufficient to cause him to momentarily lose consciousness and slump to the floor. If this was the case, he clearly did not remain unconscious as evidenced by the struggle that he put up when the officers entered the cell and attempted to restrain him. But such a temporary restriction of air may have started a process, such as cardiac arrhythmia, which then led to asphyxia resulting in his death.

[71] By the time the Corrections Officers entered the cell and began their restraint of Mr Harris, it is likely that the asphyxiation process was already in train. I base this conclusion on the fact that he had collapsed, and on Dr Stables' evidence that restriction of oxygen or blood flow may trigger an arrhythmia. The restraint of Mr Harris by the Corrections Officers has then exacerbated the asphyxiation process by virtue of him being restrained while lying prone on the cell floor with the considerable weight of his torso applying significant pressure on his lungs and diaphragm. This is likely to have restricted his ability to breathe. Mr Harris was lying prone for approximately five minutes. The attempts to mitigate the risk of positional/restraint asphyxiation by SCO 4 and other officers were ineffective, probably because of the size and weight of Mr Harris and his struggling against the officers.

Conclusions

[72] I consider that Mr Harris' death was due to the combination of the following factors:

(a). Mr Harris' actions and behaviour:

- He had been abusive and aggressive towards other prisoners and Corrections Officers, including making threats of physical harm to the officers, and had damaged prison property. This created an extremely high level of risk around Mr Harris, given his size and strength.
- Mr Harris gave the impression to prison staff that he intended to self-harm, by tying cloth around his neck and indicating strangulation, accompanied by a verbal threat to hang himself. This necessitated urgent intervention by the Corrections Officers outside his cell, resulting in entry to the cell.
- The strenuous and prolonged resistance by Mr Harris to the officers' attempts to apply approved locks on his arms and legs, resulting in him being held on the floor in a prone position for an extended period of time.

(b). The very poor state of Mr Harris' cardiac health and his morbid obesity. It is likely that these underlying medical conditions made Mr Harris more susceptible to the effects of oxygen restriction.

(c). The restraint of Mr Harris in a prone position on the cell floor by a number of Corrections Officers.

[73] It is clear to me that the major contributing factors in the death of Mr Harris were his attitude and behaviour toward the Corrections Officers, which necessitated a robust spontaneous control and restraint process, coupled with his strenuous and continued resistance to this restraint. If Mr Harris had not created a high degree of risk around himself, and if he had been compliant rather than resistant, then it is likely that the officers who entered his cell would have been able to assess his medical condition much earlier. Whether or not Mr Harris would have then survived this incident I am unable to say, given the uncertainty as to exactly what medical event may have been occurring at the time, and the dire condition of his heart.

[74] I am satisfied from the evidence before me that this death occurred during a justifiable and necessary restraint of an aggressive, threatening and struggling prisoner, and that the restraint was carried out in accordance with the guidelines covering restraint procedures.

Submissions by the Harris Family on Comment on Conduct

[75] Counsel for the Harris family made submissions on proposed comment on the conduct of Mr Harris. The first submission was that a robust control and restraint process was not appropriate given that Mr Harris had not carried out any acts of violence against any Corrections Officers, and given his known physical and mental health issues. I do not accept that submission. I acknowledge that Mr Harris had not assaulted any staff prior to the control and restraint, but I consider that his threats of violence directed specifically at staff created the need for a significant number of staff to carry out the restraint. Furthermore, his resistance to the attempts to restrain him necessitated a commensurate level of force.

[76] Mr Harris' medical and mental health issues were known to the officers, but when faced with resistance from a very strong and powerful prisoner who had threatened violence against officers, the officers had to restrain the prisoner. In doing so, the evidence of the officers was that they attempted to mitigate the risk of harm to Mr Harris. Unfortunately this was ineffective. If Mr Harris had not resisted, then the control and restraint procedure would have been over with much more quickly and Mr Harris would not have been held down on the floor for an extended period of time.

[77] With regard to counsel's submissions on mental health issues, specifically that prison staff should have considered his mental state when considering and executing their restraint of Mr Harris, the evidence was that the control and restraint was a matter of urgency. Therefore staff did not have the luxury of considering Mr Harris' mental state before entering the cell and commencing the control and restraint procedure. In addition, because of the threats of violence made by Mr Harris, his size and strength, and his resistance to the restraint process, his mental state was not a matter that the officers could accommodate in any particular way.

FORMAL FINDING

[78] I find that Nicholas Ward Harris died at Waikeria Prison, Waikeria Road, Te Awamutu, on 9 January 2011.

[79] The cause of death was asphyxia of an undetermined cause, initiated either by self-strangulation or a pre-existing medical condition, but in combination with restraint, with an underlying condition of morbid obesity with secondary dilated cardiomyopathy.

[80] The circumstances of the death are that Mr Harris died while being restrained in a prone position on the floor of his prison cell by a number of Corrections Officers. The officers had entered his cell due to a concern that Mr Harris may be attempting self-harm. When the officers attempted to apply approved control and restraint locks on Mr Harris, he resisted strenuously for approximately five minutes. At that point Mr Harris ceased struggling and was noted to be unresponsive. Medical assistance was immediately provided to Mr Harris but he could not be resuscitated.

COMMENTS/RECOMMENDATIONS

[81] I note that the recommendations contained in the Inspectorate report have been addressed by the agencies they were directed to. I therefore do not consider it necessary for me to make any recommendations pertaining to the matters in the Inspectorate report.

[82] I have considered whether I need to make a recommendation in relation to the failure by Master Control to inform the team of officers about to enter Mr Harris' cell of the fact that Mr Harris had slumped onto the floor. Having considered the evidence provided, I do not feel the need to make a recommendation. I believe that Waikeria Prison management will take on board my comments on this issue and will give consideration to whether this issue needs to be addressed by way of staff training.

[83] With any unnatural death that occurs in an institution, there are usually learnings which can be found through a close examination of the circumstances surrounding the death that relate to the systems or procedures of that institution. In this particular case, a comprehensive Inspectorate report has been completed, as well as this inquest with six days of evidence. I am confident that, if there are any other learnings to be gleaned by the Department of Corrections from this very unfortunate death, then that department will take cognizance of those learnings and will consider whether such systems or procedures can be improved.

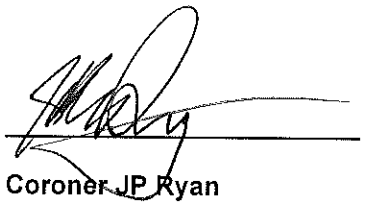
RESTRICTION ON PUBLICATION

[84] Pursuant to section 74 of the Coroners Act 2006, I prohibit the making public of:

(a). Any photographs taken of Mr Harris following his death; and

(b). Any details of any of the Corrections Officers or nurses at Waikeria Prison who were directly involved in dealing with Mr Harris on 9 January 2011 that may lead to the identification of those officers or nurses

on the grounds that it is in the interests of justice, decency, public order, or personal privacy to do so.



Coroner JP Ryan