

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Harness, a prisoner at HMP Leeds, on 26 April 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 David Harness was found hanging in his cell at HMP Leeds on 26 April 2019. He was 38 years old. I offer my condolences to Mr Harness' family and friends.

When Mr Harness was moved to Leeds from HMP Lindholme on 13 August 2018, he was being monitored under suicide and self-harm procedures (known as ACCT). Staff at Leeds stopped ACCT monitoring the next day and he was not monitored under ACCT again.

Mr Harness had a history of substance misuse and completed a drug detoxification programme at Leeds. However, he told staff that he continued to use illicit substances as a means of coping.

In January and March 2019, Mr Harness told staff that he had concerns about his mental health and he asked to speak to someone from the mental health team. The mental health team gave him self-help materials but did not assess him.

The investigation found that the decision to stop ACCT monitoring on 14 August 2018 was reasonable and that Mr Harness gave little indication that he was at imminent risk of suicide in the weeks leading up to his death. However, it found that Mr Harness should have been offered a face-to-face mental health assessment when he told staff he had concerns about his mental health in early 2019, and his care in that respect was not equivalent to that which he could have expected to receive in the community.

We have identified inadequacies in mental health assessments in previous investigations into deaths at Leeds and this issue must now be addressed.

The investigation also found that Mr Harness' continued drug use, including a drug test failure, was not communicated to healthcare staff. There were also failings in the emergency response, though I am satisfied they did not affect the outcome for Mr Harness.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2021

Contents

Summary	1
The Investigation Process.....	3
Background Information	4
Key Events.....	6
Findings	11

Summary

Events

1. Mr David Harness was recalled to prison on 11 April 2018 and sent to HMP Leeds. He was moved to HMP Lindholme on 17 May.
2. On 3 August, staff started suicide and self-harm procedures (known as ACCT) after Mr Harness was found hiding in the stores area of a workshop with a length of knotted sheet. On 13 August, Mr Harness was moved back to Leeds. Staff stopped ACCT monitoring the next day.
3. Mr Harness had a history of substance misuse and was prescribed methadone as part of a drug detoxification programme, monitored by the clinical substance misuse service (Integrated Drug Treatment Service – IDTS). On 3 December, Mr Harness failed a mandatory drug test (MDT) after he tested positive for psychoactive substances (PS), but IDTS was not told.
4. On 29 January 2019, Mr Harness told a mental health nurse on the wing that he was having violent thoughts towards other prisoners and said he needed to speak to someone from the mental health team. He was offered group work to address his anger management and emotional control, but he refused this.
5. On 12 February, Mr Harness completed his drug detoxification programme but told staff that he was struggling to cope in prison and he was continuing to use illicit drugs.
6. Around 11 March, Mr Harness submitted an undated application to the mental health team saying he was stressed and needed to speak to someone. The mental health team discussed his request and provided him with self-help materials, but they did not offer him a face-to-face assessment.
7. On 15 March, Mr Harness told a mental health nurse on the wing that he had wanted to speak to someone in the mental health team but had just been given self-help materials. He said he saw no future other than being in prison. Mr Harness said he was taking illicit drugs to cope. The nurse encouraged him to look at the self-help leaflets and referred him to chaplaincy for support. Mr Harness had no further contact with the mental health team.
8. At around 7.50am on 26 April, an officer found Mr Harness hanging from the medicine cabinet behind his door. The officer used his radio to call an emergency code, cut down Mr Harness and started cardiopulmonary resuscitation (CPR) assisted by other prison staff. The first medical responder arrived within two minutes, but he did not have any emergency equipment with him. Another nurse arrived around four minutes later with an emergency bag and equipment. Staff continued with CPR until the paramedics arrived at 7.58am. The paramedics were unable to resuscitate Mr Harness and at 8.20am, he was pronounced dead.
9. Toxicology tests showed that Mr Harness had PS in his system when he died.

Findings

10. We found that the decision to stop ACCT monitoring the day after Mr Harness arrived at Leeds was a reasonable one. Mr Harness said he wanted to move from Lindholme and was happy in Leeds, his caremap actions had been completed, and his risk was assessed as low. We are satisfied that the ACCT process was appropriately managed.
11. We found that Mr Harness' mental health care was not equivalent to that which he could have expected to receive in the community. We consider that Mr Harness should have been offered a face-to-face mental health appointment to assess his needs.
12. We have found failings in the adequacy of mental health assessments in previous investigations into deaths at Leeds.
13. When the emergency code was called, the first emergency responder arrived promptly, but he did not have an emergency bag or any equipment with him. While we consider that this had no impact on the eventual outcome for Mr Harness, we are concerned that any delay in providing the necessary emergency equipment could be crucial in future incidents.
14. Despite failing a mandatory drug test in December 2018 and telling prison staff that he was continuing to use illicit drugs, we found no evidence that this information was shared with IDTS or that further drug tests were carried out.
15. Mr Harness had used PS before he died. We cannot say what effect, if any, this had on his actions.

Recommendations

- The Head of Healthcare should ensure that:
 - referrals to the mental health team receive a face-to-face assessment;
 - all staff are trained in the use of self-help materials; and
 - the effectiveness of self-help materials is appropriately assessed.
- The Operational Manager should work with NHS England to ensure that the provision and delivery of mental health services is adequate for the needs of the prison's population.
- The Head of Healthcare should ensure that the dedicated first emergency responder is equipped with emergency equipment and oxygen.
- The Operational Manager and Head of Healthcare should ensure that there is a more robust method of sharing Mandatory Drug Test results between prison and healthcare staff, especially when the prisoner is receiving drug detoxification medication.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator obtained copies of relevant extracts from Mr Harness' prison and medical records.
18. NHS England commissioned a clinical reviewer to review Mr Harness' clinical care at the prison.
19. The investigator and clinical reviewer jointly interviewed six members of staff at Leeds. The investigator also separately interviewed one prisoner at Leeds and two members of staff by telephone. The interviews took place between May and September 2019.
20. We informed HM Coroner for West Yorkshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. We contacted Mr Harness' sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Harness' sister did not have any specific questions.
22. We shared our initial report with Mr Harness' sister. She did not raise any factual inaccuracies.
23. We shared our initial report with the Prison Service. They did not raise any factual inaccuracies. The action plan has been annexed to this report.

Background Information

HMP Leeds

24. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including clinical substance misuse and mental health services. The prison has 24-hour primary healthcare cover.
25. In August 2018, Leeds was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focussing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Leeds was in November 2017. Inspectors found Leeds to be an unsafe prison. They found the levels of self-harm were significantly higher compared to those of other local prisons. Inspectors found initial ACCT assessments were generally good, and reviews were often multidisciplinary. However, caremaps were inadequate and observations recorded by staff lacked meaningful interaction with prisoners. Inspectors considered that healthcare services remained reasonable, but triage clinics for mental health were not used effectively.

Independent Monitoring Board

27. 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. The IMB report for the year ending December 2018, found that prisoners were treated with humanity and respect given the current staff constraints. The Board noted that the availability of psychoactive substances (PS) had posed particular challenges. Some of the money provided to Leeds as part of the “10 Prisons Project” had been spent on a body scanner in reception to detect drugs and new netting over the exercise yards to prevent drugs being thrown over.
28. The Board noted that Leeds had no dedicated mental health facility to care for prisoners with significant mental ill health. They urged NHS England to conduct an urgent needs assessment on the provision and delivery of mental health services at Leeds.

Previous deaths at HMP Leeds

29. Mr Harness was the 18th prisoner to die at HMP Leeds since April 2017. Of the previous deaths, seven were self-inflicted, seven were from natural causes, two were drug-related, and one was a homicide. There have been five deaths since - three from natural causes, one self-inflicted and one awaiting classification. We have identified inadequacies in mental health assessments in five previous investigations.

Mandatory Drug Testing (MDT)

30. Prisoners are legally required to provide a sample, on request, for the purposes of drug testing. While MDT alone cannot solve the problem of drugs within prisons, it can contribute to the overall objective of reducing drug misuse when used as part of a wider and more comprehensive drug strategy. The objectives of MDT are to increase the detection of those misusing drugs, to help prisoners resist peer pressure to become involved in drug taking, to offer appropriate support to those who want to combat their drug problems, and to help identify the scale, trend, types and patterns of drug misuse in individual establishments. Prison Service Order (PSO) 3601 sets out the procedures and mandatory requirements for carrying out MDT. Target levels of between 5-15% of the prison population are expected to be randomly tested each month. Additional testing can take place if prisoners are suspected of using illicit drugs.

Key Events

31. Mr David Harness was sentenced to 58 months in prison on 1 May 2014 for robbery. He was released on licence on 20 October 2017 but recalled on 11 April 2018 after committing a further offence. He was sent to Leeds but was moved to HMP Lindholme on 17 May. Due to his recall, Mr Harness' conditional release date was 5 November 2023, unless the parole board directed his release earlier.
32. Mr Harness had a history of alcohol misuse and illicit drug use. He was put on a drug detoxification programme where he was prescribed methadone (an opiate substitute) daily, monitored by the clinical substance misuse service (Integrated Drug and Alcohol Services - IDTS). Mr Harness was also prescribed regular pain relief medication for a back injury he sustained in a car accident in 2012. He told staff that he had also suffered a brain injury during the accident which affected his memory.
33. On 3 August 2018, Mr Harness went missing at Lindholme and was found hiding in the stores area of the workshop. Staff described him as being non-communicative and withdrawn when they found him. He also had approximately 15 feet of knotted sheet so they started suicide and self-harm procedures (known as ACCT). Staff were also concerned that Mr Harness may have been trying to escape so he was moved to the segregation unit and placed on the escape list. Mr Harness later told staff that he was afraid he was going to stab a prisoner who had accused him of stealing a mobile phone. He said he had asked staff for help about how he was feeling but no one responded. He complained about the attitude of staff and the lack of support, but said he had no thoughts of suicide or self-harm.
34. On 13 August, Mr Harness was moved back to Leeds. He was still being monitored under ACCT procedures at the time and staff at Lindholme carried out an ACCT review prior to transfer. They noted that Mr Harness was happy to be moving to Leeds and they had no concerns about suicide or self-harm. On reception at Leeds, staff noted that Mr Harness had a history of depression and self-harm, but he said he declined support from the mental health team. He was referred to IDTS and to see the doctor.
35. At 7.20pm on 13 August, a Custodial Manager (CM) and a Supervising Officer (SO) carried out the first ACCT review at Leeds (the fourth review on this period of ACCT monitoring) with Mr Harness. Mr Harness told them that he had mistakenly fallen asleep in the greenhouse at Lindholme and he had not tried to escape. He said he did not know why staff started ACCT monitoring. The CM and the SO assessed Mr Harness' risk as low, set observations as three during the day and three during the night, and arranged a further review for the next day.
36. On 14 August, a CM chaired the fifth ACCT review. The review was also attended by a nurse from the mental health team. An officer from the Safer Custody team provided verbal input. Mr Harness said again that he did not know why he was being monitored under ACCT procedures. He said he was happy to

be at Leeds and had no thoughts of suicide or self-harm. Staff stopped ACCT monitoring and set a post-closure interview for 21 August.

37. On 21 August, at the ACCT post-closure interview, the CM noted that Mr Harness said he had not thought of self-harm and he had the support of friends and staff on B Wing. The CM noted that Mr Harness was awaiting work allocation and he was engaging fully with the wing regime.
38. In the following months, Mr Harness' record shows he received over 13 positive behaviour entries for helping others and going above and beyond what was required of him. His records show that he was a helpful and supportive prisoner who had a trusted job as a wing cleaner. There was no indication of any negative behaviour or illicit drug use.
39. However, a mandatory drug test (MDT) taken on 3 December showed a positive result for psychoactive substances (PS) and on 10 December, Mr Harness was placed on report (a disciplinary charge). Although staff recorded the positive drug test result in Mr Harness' prison record and in the prison's security system, it was not communicated to the healthcare team even though Mr Harness was being prescribed methadone as part of a drug detoxification programme. The Head of Healthcare told the clinical reviewer that the MDT process is carried out by prison security staff and that the sharing of information with healthcare could be "hit and miss".
40. When Mr Harness attended his weekly IDTS clinic appointments on 11 and 18 December, he told a substance misuse worker that he had not used any illicit substances. Mr Harness continued to receive his methadone but we found no evidence that his denial of illicit drug use was challenged or that any further drug tests were considered in order to test his compliance with the detoxification treatment.
41. On 29 January 2019, Mr Harness approached a mental health nurse, while she was on the wing. The nurse noted in Mr Harness' medical records that he told her he was having thoughts of harming other prisoners, he was feeling stressed, and he was concerned for his mental health. He said that he wanted to speak to someone from the mental health team. The nurse noted that she spoke to him about group work to address his anger management and emotional regulation but he declined, saying group work was not suitable for him. She offered to contact the probation service to source some psychological work around violence. The nurse noted that, at the mention of her contacting the probation service, Mr Harness became irate and accused her of breaching his medical confidentiality. Even when she said she would not speak to probation, he continued to be angry with her and walked away while she was trying to talk to him. The nurse noted in his medical record that Mr Harness did not display any obvious mental health problem and she did not consider that he required input from the mental health team. She informed wing staff of her interaction with Mr Harness and submitted an intelligence report.
42. On 31 January, Mr Harness met his Drug and Alcohol Recovery Team (DART) worker. (DART provides psychological support to those with substance misuse issues.) The DART worker noted that Mr Harness was close to finishing his detoxification. Mr Harness was concerned that he might feel stressed and

require a “day out” (use illicit drugs) and he requested one-to-one work to focus on his triggers for drug use. The DART worker agreed to work with him on a fortnightly basis to address this.

43. On 3 February, Mr Harness was punched by another prisoner which was witnessed by staff. Mr Harness said that he and the prisoner were in a dispute over the menu plans, for which Mr Harness was responsible. Staff took appropriate disciplinary action against the prisoner who punched Mr Harness. Mr Harness was offered victim support after the assault but he declined. Staff considered this was an isolated incident and there were no further violent incidents involving Mr Harness, either as a victim or a perpetrator.
44. On 12 February, a substance misuse worker wrote in Mr Harness’ medical record that he had completed his detoxification.
45. On 13 February, Mr Harness saw a prison GP to discuss pain management for the back injury he sustained in a car accident in 2012. He had previously been prescribed gabapentin and co-codamol but was requesting dihydrocodeine. Both gabapentin and dihydrocodeine are open to misuse within a prison setting and the prison GP noted that Mr Harness had been suspected of diverting his pain management medication in the past. However, the prison GP assessed that Mr Harness was not displaying drug-seeking behaviour and she considered his pain could be better managed with the use of dihydrocodeine. She agreed to stop co-codamol, reduce his use of gabapentin and introduce dihydrocodeine. The prison GP also referred Mr Harness for a spinal X-ray and agreed to review him in three to four weeks.
46. On 13 March, Mr Harness met with his DART worker. This was the first time they had met since 31 January, when the DART worker agreed to fortnightly one-to-one sessions. Mr Harness told his DART worker that he was continuing to use illicit substances, including opiate-based prescription medication he had obtained from other prisoners. Mr Harness expressed feelings of hopelessness and said he lacked motivation to do anything, including his job as a cleaner on B Wing. Mr Harness told his DART worker that he had a parole hearing coming up but he did not believe he was going to be released. The DART worker encouraged him to find ways to increase his motivation, such as using the gym, and agreed to see him again the next week. The DART worker told the investigator and the clinical reviewer that he told wing staff that Mr Harness had admitted to using illicit drugs but we found no evidence of this in Mr Harness’ records.
47. On 14 March, the mental health nurse who had seen Mr Harness on 29 January, wrote in Mr Harness’ medical notes that the mental health team had received an undated application from him on 11 March, saying he needed to speak to someone from the mental health team. He said he was stressed and it was starting to affect his daily routine. She noted that she discussed Mr Harness’ case with the mental health team. Taking into account the issues identified in her previous encounter with Mr Harness, the team decided that self-help materials would be appropriate for Mr Harness. The nurse noted that this was in accordance with the mental health pathway and that she would also let him know about other avenues of support. Nothing is recorded to say if Mr Harness had any face-to-face contact with the mental health team when he was given the self-

help materials or whether he received advice about other support networks. The nurse wrote that no further input was required from the mental health team.

48. On 15 March, Mr Harness approached another mental health nurse, when she was on the wing. She wrote in Mr Harness' medical records that she had known him for a long time and felt they had a good rapport. He told her he was frustrated about his sentence progression and that he felt his offender supervisor was avoiding him. He said he felt he had no future other than being in prison. Mr Harness said that he wanted to talk to someone about his issues but, instead, he had been given self-help materials. He admitted to using illicit drugs every night in order to cope. The nurse noted in his medical records that she encouraged Mr Harness to use the self-help materials and to talk to other prisoners facing similar issues around their sentence. She also referred him to the chaplaincy for support. Mr Harness did not have any further involvement with the mental health team.
49. On 19 March, Mr Harness' DART worker met with him to start structured counselling work around his substance misuse. Mr Harness said that he was still using illicit drugs. His DART worker made an appointment to see him again the next week.
50. On 21 March, Mr Harness had an appointment with a prison GP. He told her that, due to his brain injury, he was easily distracted and had problems retaining information. The prison GP agreed to look at brain injury services that might be available to him. She continued to prescribe dihydrocodeine for his back pain.
51. On 3 April, Mr Harness was due to meet with his offender supervisor and his offender manager (probation officer) to discuss his parole reports. The appointment had to be rescheduled as staff did not unlock him for the visit. His offender supervisor noted that Mr Harness was very angry about the cancelled appointment and said he wanted another face-to-face appointment arranged with his offender manager.
52. On 4 April, a DART worker went to see Mr Harness for a substance misuse appointment. Mr Harness told her that he no longer wanted to engage with DART.
53. On 9 April, Mr Harness met with his offender supervisor and his offender manager to gather information for his parole reports. The offender supervisor told the investigator and the clinical reviewer that Mr Harness did not want to be released to a probation approved premises and said that he would rather stay in prison until his conditional release date in November 2023. The offender supervisor said that Mr Harness wanted to move to open conditions, but this was not considered an option based on his risk and custodial behaviour. No decision was made at the meeting but his offender manager and offender supervisor were to prepare their reports for the parole board. The offender supervisor said that Mr Harness would have been aware of the two options available but he did not know which was being put forward to the parole board.
54. On 24 and 25 April, Mr Harness was feeling unwell and spent most of his time in his cell. Another prisoner told the investigator that he thought Mr Harness was suffering with an upset stomach. He said that Mr Harness had asked him to get

him a vape on the evening of 25 April but he was unable to get one for him. The prisoner said that he thought Mr Harness had been feeling unwell because he had been trying to stop using illicit drugs but he believed he wanted the vape for drugs. He said he last saw Mr Harness at around 7.00pm on 25 April.

55. On the morning of 26 April, an officer completed the morning roll check at around 5.20am and said he saw Mr Harness lying on his bed. At around 7.45am, another officer started unlocking prisoners. When he pushed open the door to Mr Harness' cell, the door bounced back and he did not get a response from him. The officer looked around the door of the cell and saw that Mr Harness was hanging from the medicine cabinet behind the door. He immediately called a code blue (an emergency code which tells the control room that a prisoner is unresponsive or not breathing and that an ambulance needs to be called immediately) and reached around the door to cut the ligature. Other prison staff attended and helped to push the door open. The officer started cardiopulmonary resuscitation (CPR) assisted by a CM.
56. The first emergency responder was a nurse. He arrived within two minutes of the code blue call at 7.52am but he did not have an emergency bag or any equipment with him. At interview, the nurse said that he felt his priority was to get to the emergency and then ask another nurse to bring the emergency bag. Another nurse arrived at 7.56am with the emergency bag and oxygen. Staff continued with CPR until paramedics arrived at 7.58am. Paramedics were unable to resuscitate Mr Harness and, at 8.20am, they pronounced that he had died.

Contact with Mr Harness' family

57. The prison's family liaison officer (FLO) tried to contact Mr Harness' sister who he had listed as his next of kin, but he had given an incorrect address and telephone number. The FLO and a SO therefore visited the home of Mr Harness' ex-partner on the afternoon of 24 April to tell her that Mr Harness had died. Mr Harness' ex-partner put them in touch with his sister and the FLO was then able to liaise with her as the correct next of kin. The prison contributed to the cost of Mr Harness' funeral in line with national guidance.

Support for prisoners and staff

58. After Mr Harness' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
59. The prison posted notices informing other prisoners of Mr Harness' 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 Harness' death.

Post-mortem report

60. The post-mortem report concluded that Mr Harness' death was due to hanging. Traces of illicit substances, including PS, were found in his blood but it was not possible to establish what impact these substances may have had on his actions.

Findings

Management of Mr Harness' risk of suicide and self-harm

61. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, gives guidance to staff on how to identify, manage and support prisoners who are at risk of harm to themselves or others. It sets out the procedures (known as ACCT) that must be followed whenever staff assess that a prisoner is at risk of suicide or self-harm.
62. When Mr Harness was moved from Lindholme to Leeds on 13 August 2018, he was being monitored under ACCT procedures. Staff at Leeds conducted an ACCT review on the day he arrived and set a further review for the following day. A CM chaired the ACCT review on 14 August, which was also attended by someone from the mental health team, and considered that Mr Harness' risk was low and the caremap actions had been completed. Mr Harness said he was happy to be at Leeds. We consider the decision to close the ACCT on 14 August was a reasonable one and the ACCT was managed in accordance with PSI 64/2011. We found no evidence that staff should have considered starting ACCT procedures at any other time when Mr Harness was at Leeds. We therefore make no recommendation.

Mental health

63. Mr Harness had a history of depression and self-harm, although he had no formal mental health diagnosis. He had made previous attempts to take his life in prison, most recently in 2015. Records show that he declined antidepressant medication and support from the mental health team when he was in prison.
64. However, when Mr Harness approached a mental health nurse on 29 January, he was concerned about violent thoughts towards others and said he needed to speak to someone about his mental health. The nurse suggested anger management and emotional regulation group work that he did not want to do and he quickly ended the conversation when she mentioned speaking to his offender manager. She wrote a detailed entry in Mr Harness' medical record, but no further action was taken to discuss the issues with him or to consider what support he might need.
65. The nurse later discussed Mr Harness at a mental health team meeting on 14 March after he again requested mental health support. The team decided that Mr Harness should be given self-help materials. The clinical reviewer commented that assessments of anxiety and depression scores should be carried out before, during and after the use of self-help materials. We found no evidence that any such assessment was carried out or that the effectiveness of the self-help materials was monitored in any way. When Mr Harness raised his objections about the lack of face-to-face support with a nurse on 15 March and told her that he was struggling with his sentence progression and using illicit substances in order to cope, she simply encouraged him to use the self-help materials and referred him to the chaplaincy.
66. We consider there were missed opportunities to provide Mr Harness with the mental health support he might have needed. Given that he was expressing

concerns about hurting other prisoners and feelings of hopelessness, we would have expected him to be offered a face-to-face assessment with someone from the mental health team. This did not happen. The clinical reviewer concluded that Mr Harness' mental health care was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that:

- **referrals to the mental health team receive a face-to-face assessment;**
- **all staff are trained in the use of self-help materials; and**
- **the effectiveness of self-help materials is appropriately assessed.**

67. We have identified inadequacies in mental health assessments in a number of previous investigations into deaths at Leeds. We also note that the IMB has urged NHS England to conduct an urgent needs assessment on the provision and delivery of mental health services at Leeds. We, therefore, make the following recommendation:

The Governor should work with NHS England to ensure that the provision and delivery of mental health services is adequate for the needs of the prison's population.

Emergency response

68. A nurse was the designated first emergency responder but he did not bring an emergency bag or oxygen. While we are satisfied that CPR was carried out to a good standard and that the delay in bringing the emergency bag did not affect the eventual outcome for Mr Harness, we consider that the correct emergency equipment should be brought to an emergency as soon as possible as such a delay could be crucial in other similar incidents. We therefore make the following recommendation:

The Head of Healthcare should ensure that the dedicated first emergency responder is equipped with emergency equipment and oxygen.

Substance misuse

69. Mr Harness had a history of using illicit drugs. During his time at Leeds, he engaged with IDTS and completed a drug detoxification programme using methadone. Despite this, Mr Harness continued to use illicit drugs in prison and openly disclosed this to staff. When he failed an MDT in December 2018, we found no evidence that IDTS staff were made aware of this or that anyone took appropriate action to challenge Mr Harness about using drugs whilst undergoing detoxification. Additionally, we found no evidence that Mr Harness had any further drug testing to see if he was complying with the detoxification programme.
70. On 15 March 2019, Mr Harness told a mental health nurse that he was using illicit drugs every night. There is no evidence that this information was shared with prison staff, other healthcare staff or IDTS.
71. After Mr Harness' death, toxicology tests showed the presence of a number of illicit drugs in his system and an unknown liquid was found in two latex balls in

his cell. The clinical reviewer commented that, although Mr Harness' substance misuse care was of a good standard, there were missed opportunities to address his illicit drug use. We also share the clinical reviewer's concerns about the lack of drug testing.

72. The Head of Healthcare told the clinical reviewer that the process for drug testing and sharing information is "hit and miss". We consider that this should be tightened up to ensure that prisoners who are undergoing drug detoxification are tested on a regular basis to check their compliance, and that results of MDTs are appropriately shared between prison and healthcare staff. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a more robust method of sharing MDT results between prison and healthcare staff, especially where the prisoner is receiving drug detoxification medication.

Violence reduction

73. Mr Harness was assaulted by another prisoner on 3 February 2019. We are satisfied that the prison investigated this in line with its own policy and the national Challenge, Support and Intervention Plan (CSIP). Mr Harness told staff it was an isolated incident concerning prisoner menus, for which he had responsibility. We are satisfied staff took appropriate action. We do not consider that this incident was linked to a pattern of bullying or drug-related violence and we make no recommendation.

**Prisons &
Probation**

Ombudsman
Independent Investigations