REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **THIS REPORT IS BEING SENT TO:** **CHIEF EXECUTIVE SWANSEA BAY UNIVERSITY HEALTH BOARD** **1 TALBOT GATEWAY** **BAGLAN ENERGY PARK** **BAGLAN** **PORT TALBOT** **SA12 7BR** **JUDITH PAGET CBE** **DIRCTOR GENERAL OF HEALTH AND SOCIAL SERVICES / CHIEF EXECUTIVE OF NHS WALES** **TY DYSGU,** **NANTGARW,** **CF15 7QQ.** **MARTIN NICHOLLS** **CHIEF EXECUTIVE OF THE CITY AND COUNTY OF SWANSEA** **Martin.Nicholls@swansea.gov.uk**
1	**CORONER** I am Kirsten Heaven, Assistant Coroner, for the Coroner area of SWANSEA & NEATH PORT TALBOT
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INVESTIGATION and INQUEST On 12 April 2022 an investigation was commenced into the death of Nicholas Kim Harrison. The investigation concluded at the end of the inquest on 16 April 2024. The medical cause of death was: 1a Hypoxic-Ischaemic Brain Injury 1b Traumatic Brain Injury The conclusion of the inquest was a narrative conclusion as follows: On 12 March 2022 Kim Harrison was seriously assaulted by his son the perpetrator at the family home. As a result of this assault Kim sustained significant head and face injuries which caused his death on 9 April 2022. At the time of the assault, the perpetrator had absconded from Ward F of Neath and Port Talbot hospital where he was subject to detention powers under section 2 of the Mental Health Act 1983 following an informal admission on 2 March 2022. The perpetrator had been detained

as doctors considered that he posed a potential risk of violence to others. At the time of the assault the perpetrator was suffering from untreated schizophrenia which caused him to have paranoid delusions about his father.

The perpetrator had been receiving care and treatment from Swansea Bay University Health Board ('SBUHB') for his mental ill health from 2007 onwards which included taking the drug Olanzapine. In 2009 the perpetrator was wrongly removed from the care of Area 3 Community Mental Health Team. This contributed to a lack of continuity in care for the perpetrator in 2018 when his treating consultant left. At this point SBUHB failed to put in place appropriate and timely follow-up arrangements from a replacement consultant psychiatrist which caused the perpetrator to become disengaged from services when he was vulnerable. This caused the perpetrator to wean himself off Olanzapine in an unmanaged and unmonitored way. This led to a return of the perpetrator's psychotic symptoms and a deterioration in the perpetrator's mental health to the point where the perpetrator lost insight into his condition and his risk to himself, and others, began to increase. The perpetrator probably would have engaged with a suitable replacement consultant psychiatrist had one been offered by SBUHB in a timely manner in 2018 such that his mental health would not have deteriorated in the way that it did. There was a failure by SBUHB to put in place appropriate and timely follow up arrangements from a consultant psychiatrist for the perpetrator in 2018 and this contributed to Kim's death.

From June 2020 to March 2022 The perpetrator's parents Jane and Kim Harrison consistently raised with SBUHB and the City and County of Swansea AMPH service concerns about the perpetrator's deteriorating mental health in their attempts to get help for the perpetrator. The perpetrator did not want to engage with mental health services, and he did not want information to be shared with his parents as he had lost insight into his mental ill health. SBUHB clinicians and the City and Country of Swansea AMPH service did not pay sufficient attention to the collateral information being provided about the perpetrator by his family. From July 2020 onwards SBUHB clinicians, including the Community Mental Health Team, should have ensured that the perpetrator was regularly and assertively visited in the community so that the perpetrator could be re-engaged with mental health services.

The perpetrator was subject to a Mental Health Act Assessment on 27 April 2021 and not admitted to hospital for assessment. This assessment was flawed as there was a failure by SBUHB to gather all available collateral information to inform the assessment, a failure to have due regard to the collateral information during the assessment and inadequate consideration of the risks the perpetrator posed to himself and others. The assessment was also not informed by a detailed understanding of the perpetrator which would have occurred had SBUHB assertively engaged the perpetrator in the community from June 2020 onwards.

I find that these failures possibly contributed to Kim's death.

The perpetrator was admitted to Ward F on 2 March 2022 after behaving in a psychotic manner in the family home and being verbally aggressive and confrontational towards his parents. SBUHB accept that when the perpetrator was on Ward F his risk assessments were not fully completed. SBUHB also accept that the perpetrator had not been subject to an adequate multi-disciplinary team assessment and that the perpetrator's family members' views and concerns had not been fully recorded and therefore could not be taken into account and recorded on the risk assessments and that there was no clear plan in place regarding the perpetrator's non-concordance with medication. There was no documented assessment of the risk of the

	perpetrator absconding but if it had been assessed it would have been classified as a low risk. These matters did not contribute to Kim's death. On 12 March 2022 the perpetrator absconded through the front door of Ward F when it was being held open by a member of staff who was talking through the door. The security systems in place at the time in Ward F were not fit for purpose. This is because the infrastructure and design in relation to door access was unsafe and in turn was being operated in an unsafe manner due to a lack of adequate training of staff by SBUHB. This was at a time when Ward F was known to be under significant pressure. Further, this defective system was not picked up or identified through regulatory oversight by SBUHB because they had not conducted a review of the security of Ward F despite a significant increase in the rate of absconding. This system failure (defect in the security system and inadequate training of staff on door security in Ward F) contributed to Kim's death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Nicholas Kim Harrison ('Kim'). On 12 March 2022 Kim was seriously assaulted by his son Daniel Harrison ('Daniel') at the family home. As a result of this assault Kim sustained significant head and face injuries associated with a traumatic brain injury and significant neck injuries and rib fractures. Kim received intensive medical care. During this time Kim remained neurologically impaired and then died. At the time of the assault on his father, Dan had absconded from Ward F of Neath and Port Talbot hospital where he was subject to detention powers under section 2 of the Mental Health Act 1983 ('MHA 83'). Dan had been detained as he was considered to be a risk to others. At the time of the assault Dan was suffering from untreated schizophrenia which caused him to have paranoid delusions about his father, Kim.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to a concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to make a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 The first **MATTERS OF CONCERN** is as follows: I heard evidence during the inquest that in January 2021, March 2021, and December 2021 the Harrison family made three formal requests for a mental health act assessment under the MHA 83 in respect of their son Daniel in their capacity as Daniel's Nearest Relatives (NR). On receipt of a NR request, the local social services authority (City and County of Swansea ('CCoS')) is under a legal duty pursuant to s.13(4) MHA 83 to make arrangements for an Approved Mental Health Practitioner ('AMPH') to consider the patient's case as part of their consideration as to whether to make an application for admission to hospital. The Mental Health Act 1983 Code of Practice for Wales ('MHACOP Wales') states that in considering a patients case an AMPH must come to their own independent view based on social and medical evidence and that they should recognise the value in involving other people in the decision-making process where that person is able to offer a particular perspective on the patient's circumstances and that they should consult wherever possible with other

people who have been involved in the patient's care. In respect of the request in January 2021, I found that the AMPH did not collect sufficient collateral information before visiting and assessing Daniel in person and prior to the formal assessment under the MHA 83 on 9 February 2021. I also found that the assessment of 9 February 2021 was a formal assessment under the MHA 83 and that it did not comply with the MHA 83 as only one doctor and an AMPH attended to assess Daniel in person where the requirement is that two doctors must attend to assess the patient. This was not an emergency assessment. I found that in respect of the second NR request (when Daniel was in police custody in March 2021) there was a failure by the AMPH to act in accordance with the s.13(4) MHA 83 duty because it cannot be said that the AMPH adequately considered Daniel's case as sufficient collateral information was not obtained and considered prior to the decision by the AMPH not to undertake a formal mental health act assessment on Daniel whilst he was in police custody as requested by the Harrison family in their capacity as the NR. I found that the response of the AMPH service to the third NR request from the Harrison's on 19 December 2021 (which was to refuse to carry out a formal mental health act assessment) was not in accordance with s.13(4) MHA 83 as no collateral information was sought and what had been provided by the Harrison family was not afforded sufficient weight with reliance being placed solely on the records on the system which were out of date. I heard evidence during the inquest that a senior manager in the AMPH service maintained to the Swansea University Bay Health Board ('SBUHB') that the assessment of 9 February 2021 complied with the MHA 83 (when it did not) and did not at any stage make clear to the SBUHB that the AMPH service had not gathered sufficient collateral information, including that suggested by the Harrison family, prior to assessing Daniel.

I am concerned that an inadequate understanding within the CCOS AMPH service of the duty to gather sufficient collateral information in the context of any assessment under the MHA 83 and / or inadequate systems being employed within CCOS in relation to this issue creates a risk that information may not be captured and / or may be lost in relation to mentally unwell individuals in the community where they may pose a risk to their own lives and / or the lives of others and that this creates a risk that other deaths will occur.

The second **MATTERS OF CONCERN** is as follows:

It is a mandatory requirement of the MHACOP Wales that a medical examination by a doctor of a patient in a formal assessment under the MHA 83 where they are considering admission to hospital must involve consideration by that doctor of all available relevant clinical information. I heard evidence in the inquest that doctors approved under s.12 MHA 83, and used by SBUHB to conduct assessments under the MHA 83, only have access to a patient's medical records if they are employed by SBUHB. I heard that SBUHB rely heavily on s.12 doctors who are not directly employed by them and / or are locum doctors. I also heard that there is no system within SBUHB to ensure s.12 doctors are required to record the outcome of their assessment when there is a decision not to admit a patient to hospital. I heard evidence that there is no single digital record system / platform for Mental Health Services and associated access for practitioners across Wales. I am concerned that there is a system in place (or a lack of a system) in SBUHB and more widely across the NHS in Wales which is placing s.12 doctors at risk of acting contrary to the MHACOP Wales where they are unable to view a patient's medical records prior to an assessment under the MHA 83. I am concerned that this creates a risk that assessments may be flawed and / or may not detect that a person requires admission to hospital in circumstances where that patient may pose a risk to their own life and / or to the lives of others and that this

creates a risk that other deaths will occur. In addition, if a s.12 doctor is unable to record their assessment in a patient's medical records there is a risk that important information may not be documented which may be relevant to an understanding of the risk a patient may pose to themselves or others thus creating a risk that other deaths will occur.

The third **MATTER OF CONCERN** is as follows:

I heard evidence that Ward F of Neath and Port Talbot hospital is being used as the Single Point of Admission ('SPOA') for all adults requiring hospital admission in the locality for assessment of their mental illness. I heard that Ward F is a 21 bedded unit and that the move to using just Ward F as the SPOA (as opposed to three units which had been the practice) was brought in during the Covid-19 pandemic to manage the spread of the Covid 19 virus but that this change had been under consideration in SBUHB prior to the Covid-19 pandemic. I heard that this has resulted in a significantly increased level of acuity on Ward F with a significant increase in pressure on staff, a higher turnover of mentally unwell patients, and an increased pressure on staff from, for example, the need to prepare paperwork for the Mental Health Review Tribunal for Wales in a short period of time after admission. During the inquest I heard evidence (and SBUHB accepted) that the risk assessment conducted on Daniel during his time in Ward F was not adequate and that there was no assessment of Daniel's risk of absconding. I found that the pressure on staff in Ward F due to its use as the SPOA impacted on Daniel's care whilst he was on Ward F. I heard evidence from SBUHB that at the time there was insufficient training on risk assessments in Ward F. I heard from SBUHB that the current target is to ensure that 75% of staff on Ward F are trained in risk assessment by the end of 2024. I am concerned that only having 75% of staff trained in assessing risk means that risk may not be adequately assessed in respect of all patients on Ward F which raises a concern that risk to self and / or others and / or the risk of absconding will not be properly identified thus creating a risk that other deaths will occur. This is particularly so given the increased rates of acuity in the patients on Ward F due to it being used as the SPOA.

The fourth **MATTER OF CONCERN** is as follows:

During the inquest I heard that in 2021 Daniel's parents (including the deceased, Kim) became concerned that their son was not receiving appropriate care and treatment from SBUHB in circumstances where Daniel had a diagnosis of chronic psychotic disorder, had become lost to services after his consultant psychiatrist had unexpectedly left, and appeared to be suffering from a relapse in his mental health condition. Over five months (February – June 2021) the Harrison raised their concerns in writing to SBUHB in documents detailing their perceived failures around SBUHB's management of Daniel's mental health (alongside concerns raised in respect of the CCOS AMPH service). These concerns were first raised in writing in February 2021 with various updated versions of the written concerns being send on multiple occasions to SBUHB, including to the SBUHB Interim Chief Executive, the Medical Director, the Nurse Director for the Mental Health & Learning Disabilities Service Group and other members of SBUHB's senior management team. In June 2021 the Harrison's submitted a formal complaint to SBUHB after being requested to do so by the SBUHB Interim Chief Executive, who then commissioned an independent consultant psychiatrist to review the Harrison's complaint and provide an expert opinion. This expert report was received and sent to the SBUHB Interim Chief Executive in draft in November 2021 as he was directly managing the complaint. This report was critical of certain aspects of SBUHB's management of Daniel and raised

	queries for further clarification but no action was taken for 10 weeks following receipt of the expert report. I heard that this report was not shared with the consultant psychiatrist whom it criticised (and who had assessed Daniel) at any point prior to Kim's death. I found that this was a significant lost opportunity for SBUHB to reflect on some independent scrutiny that had been brough to bear on their care and treatment of Daniel before Kim's death. In the inquest I found that I had not received a satisfactory explanation for this 10-week delay and for why the report had not been shared with the treating consultant psychiatrist. Following Kim's death SBUHB undertook a Serious Incident Review which was then elevated to a formal Patient Safety Incident Investigation which was signed off in August 2023 by the SUBHB Medical Director and the SUBHB Nurse Director of the Mental Health & Learning Disabilities Service Group (17 months after Kim's death). I heard evidence that the Harrison family met with SBUHB after Kim's death and asked them to include within the formal investigation the substance of their complaint and not to limit the investigation to the time following Daniel's admission to Ward F. Both SBUHB internal investigations did not look at any aspect of Daniel's care and treatment in the community (which had formed the basis of the complaint made by the Harrisons in June 2020 and which was subject to some criticism by the independent expert). Both investigations commenced their investigations at the point at which Daniel was taken by police officers to Cefn Coed hospital and then admitted to Ward F. SBUHB responded to the Harrison's letter of compliant of June 2021 on 8 November 2023. SBUHB did not conduct a formal investigation into the Harrison's compliant. I was told by the consultant psychiatrist, who was the focus of part of the Harrison's complaint, and who had been criticised by the external expert, that he has not been interviewed by SBUHB about his involvement in Daniel's care before or after Kim's death. I have heard that SBUHB have introduced a PSIIT Investigation Protocol to ensure effective and consistent management of patient safety incidents within SBUHB. However, under this new policy the same senior leadership team who limited the scope of the Patient Safety Investigation into Kim's death in the way that I have described remain the team who decide on the scope of patient safety investigations under the new policy (the Mental Health & Learning Disabilities Service Group Senior Team). I am concerned that if there is a reluctance within SBUHB to conduct robust, transparent and timely investigations into complaints in line with the formal complaints process and if there is a reluctance within SBUHB to ensure that a formal patient safety investigation following a death and / or patient safety incident is conducted in a timely manner and is sufficiently wide in scope, including reflecting on and incorporating the concerns from the affected family member, then SBUHB will not learn lessons from patient safety incidents and that this creates a risk that deaths will continue to occur. The fifth **MATTER OF CONCERN** is as follows: I heard evidence from a SBUHB consultant psychiatrist that where a mentally unwell person in the community refuses mental health care and treatment and / or where they are hard to engage in mental health services such persons can be referred for assertive outreach in SBUHB to facilitate their engagement with services, but only if that person consents to such outreach. I also heard that assertive outreach services are available to those under secondary mental health care in SBUHB but that to be accepted for secondary mental health care a patient must consent to first being assessed. I heard that the referral forms for assertive outreach require a referrer to indicate whether a patient is consenting and if they are not consenting then the referral will not be accepted. I also heard that when a mentally unwell person refuses to engage with mental health services in the community it can be a feature of their mental ill health and an indication of their lack of insight into their illness. I am

	concerned that if consent is required before a mentally unwell person in the community is able to receive assertive outreach then there may be a gap in the mental health services within SBUHB that creates a risk that mentally unwell people will remain in the community without access to mental health services in circumstances where they may pose a risk to their own life or the lives of others. This is because whilst they may need access to mental health services, they may be too unwell to consent to that access. I am concerned that if there is such a systemic deficiency within SBUHB in relation to hard to engage mentally unwell people in the community then this creates a risk that deaths will continue to occur.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 June 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, Swansea Bay University Health Board, City and County of Swansea, South Wales Police, Jane Harrison, Daniel Harrison, Edmund Harrison, Joe Harrison, James Harrison. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	24 April 2024