GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Cadeirydd/Chairman: [redacted]
Prif Weithredwr Dros Dro/Interim Chief Executive: [redacted]

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

Rydym yn croesawu gohebiaeth yn y Gymraeg ac yn y Saesneg.
We welcome correspondence in Welsh or English.

Dyddiad / Date: 8th May 2024

Ein Cyf / Our Ref: [redacted]

FAO: Mrs Louise Hunt
Senior Coroner for Birmingham and Solihull

Dear Mrs Hunt,

RESPONSE BY SWASNEA BAY UNIVERISTY HEALTH BOARD TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS ISSUED IN THE INQUEST OF J BILLINGTON

Thank you for providing the Health Board with an opportunity to respond to your concerns raised at the conclusion of the inquest of Mr Jacob Billington.

At the outset I would wish to send my condolences on behalf of Swansea Bay University Health Board to Mr Billington's family.

In your Prevention of Further Deaths notification, you identified the following concerns and stated that it was your opinion that there is a risk that future deaths will occur unless action is taken. The Report was addressed to 5 Interested Persons and I am responding on behalf of Swansea Bay University Health Board. In the following, I will seek to outline what action we have taken to address your concerns.

The **MATTERS OF CONCERN** identified were:

1. Management of release and lack of interagency working

The management of the perpetrators release was not coordinated and there was inadequate communication between relevant agencies. In effect agencies worked in silos. Critical information is not being shared and agencies work in different IT systems meaning there is no one place where information is collated and hence a comprehensive account of matters known to each agency is not easily available to those professionals who may need to know a high risk prisoner's whereabouts on release. This concern was reinforced by evidence heard during the inquest that changes made since Jacob's death did not include resettlement information being given to Mental Health In reach teams in the prison. The failure to share information leads to a concern of future deaths as high risk seriously unwell prisoners may be released without key agencies knowing where they are meaning they are not traced and treated assertively in the community.

Response of Swansea Bay University Health Board

Swansea University Health Board recognise that there is not a shared database for interagency working in place across England and Wales prison establishments to enable the transfer and access to key information by agencies coordinating the discharge of high risk individuals.

Swansea Bay University Health Board were, at the time of Jacob Billington's death, providing Mental Health In-Reach (MHIR) services within both HMP Parc and HMP Swansea. Since September 2023 the Health Board now only provide MHIR services to HMP Swansea.

Swansea Bay University Health Board does not have the power to implement a unified IT System but evidence was provided at the Inquest regarding the changes implemented by Swansea Bay University Health Board to include the steps taken to ensure that matters within their power to aid Care Coordination and discharge planning with the relevant agencies were established. Full details are set out below to ensure high risk, seriously unwell prisoners **are not** released without key agencies knowing where, and treated assertively in the community where appropriately identified.

The MHIR Team act as a provider of care whilst the individual is in custody and ensure:

- Formal hand over of care is received from the transferring Community Mental Health Team (CMHT) or previous prison via a formal meeting
- Formal pre-release meetings are held with CMHT or transferring prison
- Receive and review the Care and Treatment Plan (CTP) and Risk Assessment (RA) within 7 days of admission and upload onto the patient record (on SystemOne)
- Facilitate 6 monthly CTP review meetings
- Undertake CTP and RA monthly audits to ensure quality and performance

Prisoners in HMP Swansea, who will be predominantly Welsh, will be subject to the Mental Health Measure (Wales) 2012 and therefore will legally be required to have a Care and Treatment Plan – this will be continued to be overseen by the individual's community Care Coordinator and the MHIR Team working in collaboration with them to ensure care provision within the custodial setting. Details of interventions conducted by the MHIR Team will be provided to the Care Coordinator as required or through the 6 monthly review meetings.

In respect of MAPPA, Swansea Bay University Health Board undertake the role of a 'Duty to Cooperate Agency' with Probation, HMP and the Police as the Responsible Authority – it is the Responsible Authority's responsibility to inform Health if a MAPPA eligible individual is scheduled for discharge and ensure we are invited to relevant meetings to coordinate release / discharge management. The MHIR Team liaise directly with the prison based Offender Management Unit and not directly with MAPPA. Liaison with MAPPA is the responsibility of the Offender Management Unit.

Discharge to Community

The MHIR Team arrange a Multi-Disciplinary Team (MDT) review meeting prior to discharge. Discharge planning is individualised depending on the patient's legal status (sentenced, or remand). When sentence end / release dates are known, MDT meetings are planned 4/6 weeks prior to identified date and these meetings are now designated as Formal Pre-Release Planning Meetings.

A Formal discharge meeting is also held between the MHIR and Primary Care Teams when patients / prisoners within the prison setting are being discharged from secondary care services (MHIR) back to primary care services within the prison. This meeting includes a full

and comprehensive handover of care and a documented discharge summary. These meetings are recorded and documented.

The MHIR CPN works with the prisoner / patient's Care Co-ordinator by completing a recovery care plan and updating current risk assessment. If the prisoner / patient is already Care Co-ordinated within the community prior to incarceration then the MHIR Team become the co-workers, working alongside the patient's Care Co-ordinator. This commences as soon as the prisoner / patient is allocated to MHIR team. The MHIR Team contact the Care Co-ordinator and request a joint meeting to update and undertake RA and care planning.

We recognise that robust discharge planning is essential, particularly links with local mental health providers, GP's and other interested parties. This is undertaken by:

- Formal pre-release meeting with CMHT / transferring prison / Probation and other agency involvement
- A discharge summary is completed and sent to the GP and given to the prisoner / patient - we issue the prisoner / patient with the discharge summary if they do not have a GP. With the prisoner / patient's consent we also provide the discharge summary to their Probation Officer
- The MHIR Team make contact with the prisoner / patient 14 days following discharge and if there is no telephone number then we cannot do the follow up phone call. We do rely on other agencies such as Offender Managers for updates if there is no phone number. If the prisoner / patient has been transferred from MHIR to a hospital then the team follow up with the ward following the 14 day period
- On a weekly basis the MHIR Team are sent the discharge information of prisoners from the Offender Management Unit (OMU). We don't request travel warrant information as the travel warrant is only issued on the day of travel. We also now have access to the prison NOMIS system which we didn't previously (training for use is being rolled out to the whole team with 50% already achieved). This system is updated by the Resettlement Team and OMU regarding release dates. These layered approaches help to avoid the risk of the team not being aware of relevant information
- A Governor Grade officer now attends the MHIR Single Point of Access Meeting and they are able to log onto NOMIS and check the release date of each patient as they are being discussed, thus providing 'live' information to the meeting

Responsible Clinician role

- Clear documentation of capacity assessment surrounding treatment
- Attendance at S.117 (Mental Health Act) and CTP review meetings under the Mental Health Measure (Wales) requirements

Governance

- The development of the MHIR Audit plan ensures processes are in place to support and drive improvement
- The service specification document / operational policy have been updated which offers detail on the function of the MHIR service
- An action plan is now generated from SPAM with actions monitored and recorded and reviewed at subsequent meetings
- A MHIR Clinical Standards document has been developed covering the following domains:
    1. Referral / Admission/ Assessment
    2. Discharge / Transfer
    3. Patient safety / experience
    4. Training / Continuous Professional Development /Support
    5. Workforce / Capacity
    6. Medicines Management
    7. Leadership and Governance
    8. Partnership working
    9. Environment

Audit findings are reported via:

- A Divisional report presented to the Mental Health & Learning Disability (MHLD) Quality and Safety Committee
- MHLD Performance Score Card
- HMP Swansea Partnership Board
- MHLD Clinical Audit Subgroup

New additions to the Service Group performance score card:

- CTP / RA monthly audit via performance score card

- Handover of care data upon discharge (Discharge planning meetings)
- Number of release notification dates received from OMU
- Handover of care meetings upon admission
- 6 Monthly CTP Meetings
- Attendance at ACCT Meetings out of number of invites (weekly)
- CTP's received from community Care Co-ordinator
- Number of patients not engaging with MHIR / action taken
- Number of patients declining medication / action taken
- Number of Did Not Attend by patients weekly in month / reason / action taken
- Number of cancelled clinics in month

There is also now improved partnership working with pharmacy regarding medication pathways and escalation of concerns in relation to non-compliance. Appropriate action is taken following review of circumstances of non-compliance.

2. SystemOne

Details of the perpetrators GP and local CMHT were not recorded in an easily accessible format. The format in which key information is recorded has now been amended at HMP Swansea to ensure the prisoner's GP details and their CMHT's details (if a person is an existing patient under a CMHT) are highlighted on a front screen/page. You were informed that this change in information management and presentation within SystemOne is unique to HMP Swansea and is not the practice in other prisons. You were concerned that there remains a risk that staff treating patients in prison may not have easy access to (and so overlook) this key information.

Response by Swansea Bay University Health Board

Swansea Bay University Health Board MHIR confirmed to the Coroner during the Inquest that they had implemented a change as detailed above within SystemOne - this was a local change. Swansea Bay University Health Board do not have the relevant system control to be able to implement a change to all SystemOne systems across the prison estates in England and Wales or to confirm what templates may already being used.

The Health Board have made contact with Product Support Centre, Digital Health and Care Wales advising of the Coroners Regulation 28 Report. The Health Board will also report at National level to NHS Wales and Prison Health in Wales to take forward.

The information included within this change allows direct access for local SystemOne users to identify the allocated MHIR worker, (if they are Care Coordinator / Co Worker or Assessor), whether they are known to or under a CMHT and have a Care Coordinator, their last known Registered GP (if known). These additions were made by the MHIR Team administrator and one of the MHIR CPN's. These details are currently accessible to any Clinician working with / seeing the prisoner / patient at HMP Swansea only.

3. **Cross agency guidance regarding release of high risk prisoners with mental health difficulties at their sentence end date.**

There are no provisions available nor any cross agency guidance in place for when a high-risk prisoner is released at sentence end date to ensure that there is adequate release planning and maximum support in the community.

Response Swansea Bay University Health Board

Swansea Bay University Health Board have no jurisdiction/power over the actions required for this concern, but have alerted the MAPPA Coordinator to this concern and asked that it is raised at the local Strategic Management Board (SMB) for consideration – the Health Board are a 'Duty to Cooperate Agency' to these arrangements and will participate in SMB discussions.

4. **West Midlands MAPPA**

West Midlands MAPPA has a prison discharge coordinator role. It was clear from the evidence at the inquest that this role was not fully understood by other agencies and what information needed to be shared was not clear. The new policy drafted by BSMHT remained confused as to which cases were to fall within the responsibility of the prison discharge coordinator role. There remains a risk of further deaths as the role is not properly understood and information sharing is not effective.

Response Swansea Bay University Health Board

Swansea Bay University does not have power to take action regarding the concern detailed.

I hope that you are assured from this response that the Health Board is taking appropriate measures within their power to address the issues that were identified during Mr Jacob Billington's inquest.

Yours sincerely,

[redacted]

INTERIM CHIEF EXECUTIVE OFFICER