Cyngor Abertawe
Swansea Council

Corporate Management Team
The Guildhall,
SWANSEA. SA1 4PE
www.swansea.gov.uk

FAO His Majesty's Assistant Coroner for
Swansea and Neath Port Talbot
[redacted]

[redacted]

Your Ref:
Date:

Nicholas Kim Harrison
19th June 2024

Dear His Majesty's Assistant Coroner

Re: Regulation 28 Report to Prevent Future Deaths – Dr Nicholas Kim Harrison who died on 9 April 2022

Thank you for your Report in relation to the Prevention of Future Deaths (hereafter "the Report") dated 24 April 2024 concerning the death of Dr Nicholas Kim Harrison on 9 April 2022.

In advance of responding to the specific concerns raised in the Report, I would like to express my sincere condolences to Dr Harrison's family and loved ones. City and County of Swansea (hereafter "the Council") fully acknowledge that this has been an extremely difficult time for them. I hope that my response provides Dr Harrison's family, and yourself, with assurance that the Council takes their loss seriously and that they have been listened to. The concerns raised in the Report have been reflected upon and appropriate action is being taken.

I have considered the Report carefully, together with the Council's Head of Adult Services and Principal Officer for Mental Health Services who oversees the management of the Approved Mental Health Professionals (hereafter "AMHP") team.

It is not within the Council's remit to respond to all of the matters of concern set out by His Majesty's Coroner in the Report, and it is appropriate that the Council responds to the first and second matters of concern. I shall address each in turn:

"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 [redacted] in their capacity as [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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 [redacted].
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 Council's response:

The Council recognises that families and other relevant persons are an integral part of the process for assessments carried out in accordance with the Mental Health Act 1983 (hereafter "the 1983 Act") and its associated Code of Practice. The Council also recognises the need to improve its AMHP services to ensure that (i) there is a robust understanding within the team of the duty to gather sufficient collateral information from family members and other relevant persons in the context of an assessment carried out under the 1983 Act, and that (ii) collateral information is consistently recorded in sufficient detail to allow subsequent AMHP and other relevant mental health professionals to have this information readily available.

With regard to His Majesty's Coroner's concern regarding the AMHP service's understanding of the duty to gather sufficient collateral information, it is important to recognise that the AMHP training course delivered by Swansea University, which all AMHPs employed by the Council are required to complete, covers (among other competencies): (i) The application of the relevant legislation and professional code of practice; (ii) Professional decision making, (iii) Exercising the function independently with insight, authority and autonomy; and (iv) Obtaining, analysing and sharing appropriate information from individuals, other professionals and sources in order to manage decision-making processes (specifically relevant to your concern).

Following completion of the AMHP training course, AMHP's employed by the Council undergo a period of shadowing and supervision by a senior and experienced AMHP and are then signed-off / approved by line management when they are deemed to be competent to fulfil the AMHP role functions on an autonomous basis. AMHPs are then required to complete 18 hours of training relevant to the role per annum. This training is arranged by the Council, and external specialist training agencies are engaged. The training includes refreshers on professional practice and legal updates.

It is also an individual AMHPs' responsibility to provide evidence of continued competence during each re-warranting period (i.e. every 3 years) and in accordance with the following key areas: (i) Values-based practice; (ii) Application of knowledge (legislation and policy); (iii) Application of knowledge (mental disorder); (iv) Application of skills (effective partnership working); and (v) Application of skills (professional decision making).

Nevertheless, and in light of His Majesty's Coroner's concerns, senior management have carried out a review with the aim of gaining a fuller understanding of this matter of individual AMHP practice and formulating recommendations and an action plan for improvement. Specific actions, to be taken within the next month, include:

i. The Council's Principal Officer for Mental Health Services will liaise with the All-Wales AMHP Group Lead with regard to this matter and His Majesty's Coroner's specific concern, and the potential benefit of, and pathway to, requesting a review of the Code of Practice, specifically the guidance relating to the gathering, weighting and recording of collateral information.

ii. The Principal Officer for Mental Health Services, in his capacity of Chair of Swansea University's AMHP training course committee, will discuss with the committee the key competence area relating to the obtaining of collateral information, and any requirement for the delivery of the course to include greater emphasis on the gathering, weighting and recording of collateral information.

iii. The Council will seek to deliver, via its external training agencies, specific refresher training to its AMHP team relating to the gathering, weighting and recording of collateral information.

iv. AMHPs are to be directed/instructed to record all relevant assessment referral and contact information on the AMHP assessment form.

v. AMHPs are to be directed/instructed to record on the AMHP assessment form the reasons for a Nearest Relative request for an assessment in as much detail as possible.

vi. The AMHP assessment form is to be updated to include an additional section for the recording of the views of relevant others or reasons for not consulting with them, and AMHPs are to be directed/instructed to complete this section in as much detail as possible.

vii. AMHPs are to be directed/instructed to record all collateral information gathered and their consideration of that information in their decision making. They are to consider having face to face contact with the individual providing collateral information before concluding assessments, and to provide rationale if it is determined that it is not necessary, appropriate or possible in the circumstances.

viii. AMHPs are to be directed/instructed to clearly document the reasons for progressing with the assessment or not. This includes full details of their discussions with medical professionals, such as any treating clinician/s, prior to a decision being made, and the rationale for the decision.

ix. Relating to the criteria for detention in accordance with the 1983 Act, AMHPs are to be directed/instructed to clearly differentiate between and record when they are in the consideration stage and formal assessment stage.

x. The AMHP assessment form is to be amended so that the analysis/comments section is positioned for earlier consideration so that there is oversight of the initial case actions for practitioners to review at an earlier stage.

xi. The AMHP assessment form is to be amended so that the section referencing the doctors involved in the assessment process prompts the detailed recording of the doctors' individual views as to the individual's case and criteria for detention. The Council's Head of Adult Services has opened dialogue with Swansea Bay University Health Board's (hereafter "SBUHB") Service Group Director of Mental Health and Learning Disabilities with regard to the requirement for doctors to record their views/conclusions on the AMHP assessment form.

xii. Audits of AMHP referrals and assessments are to be conducted quarterly for the first 12 months, then bi-annually from then on, depending on the findings of the initial quarterly audits. The audits will be undertaken by the Principal Officer for Mental Health Services with support from managers.

"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 Council's response:

This is a matter of concern for SBUHB and NHS Wales to primarily address, but the Council wishes to comment specifically in relation to access to its systems by Section 12 doctors.

The general context of Health Board professionals accessing the WCCIS system is important to recognise. Whilst the Council holds the licence and, in effect, has "ownership" of the system, SBUHB has been committed to the WCCIS programme for a number of years and has actively been involved in transition and update activity. All professionals within the SBUHB mental health service can be granted user "read only" or "read/write" access to the WCCIS system upon request. At the point of transfer from the previous PARIS system to WCCIS, all active PARIS account holders, including SBUHB professionals, had accounts created on WCCIS and were granted access rights. A joint WCCIS Mobilisation Group was in place and hosted by SBUHB to facilitate the transition.

It is a matter of SBUHB operational policy in terms of who should have WCCIS access rights and for what purpose. A new user request can be made directly to the Council's WCCIS Helpdesk or via SBUHB's service change lead. We understand that SBUHB's service change lead supports process mapping in relation to system access, and has a specific role to signpost teams and individual SBUHB users that require any access or technical support to the Helpdesk. User training can also be arranged via the Helpdesk, and there are user guides available.

WCCIS Mobilisation Meetings between the Council and SBUHB is the forum by which any operational issues may be discussed. The other suitable forum would be the Divisional Board for Mental Health, which is chaired and lead by SBUHB, but attended by the Council leads. The Council also understands that there is a SBUHB Project Board that oversees the business case and full implementation of WCCIS within SBUHB.

Specifically in relation to His Majesty's Coroner's matter of concern, Section 12 doctors are either directly employed by SBUHB or otherwise engaged by SBUHB on a non-employed/contractor basis. The Council's AMHP team chooses from an available list of Section 12 doctors provided by SBUHB. The Section 12 doctors, irrespective of their

employment status, can have "read only" or "read/write" access to the WCCIS system where SBUHB requests it and subject to contractual arrangements being agreed as to the number of users requiring access. With regard to "read/write" access, any file can be added as long as it is an approved file type (e.g. Word, PDF, JPEG, etc.). This has always been the case since the system was introduced.

The Council will continue to work with SBUHB via the various forums referred to above in order to ensure, as far as is reasonably possible, that the appropriate mental health professionals, deemed by SBUHB as requiring WCCIS access, is granted such access. Discussions have already taken place between SBUHB and the Council with the view to arranging for all patient clinical notes to be available across the relevant systems accessed by both organisations.

We hope that our responses/actions outlined above assures you and Dr Harrison's family that we have reflected on your concerns and provided reassurance as to our processes.

Yours sincerely,

[redacted]

[redacted]

Prif Weithredwr
Chief Executive