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

[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: 21st June 2024
[redacted]

To Kirsten Heaven, Assistant Coroner,
for the Coroner area of SWANSEA & NEATH PORT TALBOT

Dear Ms Heaven

RESPONSE BY SWANSEA BAY UNIVERSITY HEALTH BOARD TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS ISSUED IN THE INQUEST OF Dr NICHOLAS HARRISION

Although this is a formal response letter as part of the Regulation 28 process, we would like to start by reiterating our Health Board's apology to the family for our role in the death of Dr Harrison. We are deeply sorry for our failings in this case and recognise the enduring impact they have had on the family. We are focused on learning from our failings and committed to implementing the recommendations within the Regulation 28 report you issued.

This letter is written in response to the Report issued under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 dated notification dated 24th April 2024 wherein you identified the following concerns and stated that it was your opinion there is a risk that future deaths will occur unless action is taken.

Swansea Bay University Health Board sets out below the concerns and the action taken which is within the power of the Health Board.

CORONER'S CONCERNS

Concern 1
"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 [redacted] *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."

Swansea Bay University Health Board Response:

Whilst this concern relates to the actions of City and County of Swansea (CCOS) and not Swansea Bay University Health Board (SBUHB), the two organisations are working closely together, to ensure that all learning is identified to improve patient safety. A formal meeting has been held between the Service and Head of Adult Services and Tackling Poverty from CCOS, to identify specific actions.

A formal letter has previously been circulated (dated 3rd April 2024) to all clinical staff within the Mental Health and Learning Disabilities Service Group in SBUHB. This letter from the Mental Health and Learning Disabilities (MH&LD) Service Group Medical Director and Nurse Director, highlights the responsibility of all clinicians to ensure that all plans of care are easily accessible,

shared with all the clinical teams and that robust and accurate records are maintained for all clinical interventions.

Section 12 Approved Doctors (S12) are employed on an all Wales basis and are operationally overseen by the All Wales Approval Manager for Approved Clinicians and S12 Doctors, who is based within Betsi Cadwaladr University Health Board. The letter was previously circulated within SBUHB only and has since been shared with the Mental Health Act team managers within the other 6 Health Boards in Wales to share with the S12 Doctors, therefore covering the All Wales list. In addition, the Mental Health Act Manager within SBUHB has been instructed to send out this communication on an annual basis as a reminder of this and for any new S12 Doctors added to the list.

The training for S12 Approved Doctors is also coordinated by the All Wales Approval Manager for Approved Clinicians and Section 12 Approved Doctors, and is facilitated throughout the year. There is an initial two days training, followed by a one-day refresher training during the final two years of their current approval period (5 years). The training is provided by a KC Counsel and a Social Work Lecturer at Swansea University. The training incorporates an understanding of the powers, functions and duties of Section 12(2) Doctors, Approved Clinicians and others under the Mental Health Act 1983. The training is set within the context of the wider legal, policy and guidance framework, which govern and affect situations requiring the presence or intervention of an Approved Clinician.

The Health Board has been in contact with the All Wales Approval manager and shared the concerns and the All Wales Approval manager has confirmed that the importance of gathering collateral information prior to any assessment and ascertaining details from clinical records on the history of both medical and social circumstances is included in the training programme.

Concern 2
"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."

Swansea Bay University Health Board Response:
The Health Boards response to concern 2 covers three aspects:

- **All Wales Digital Solution**

Currently, there is not an all Wales digital solution for mental health records. Concerns about this have been escalated within the health board, with partner organisations and on an all Wales level. The design and procurement of an integrated system is being taken forward via the West Glamorgan Regional Connecting Care Programme Board, with Digital Health Care Wales (DHCW).

- **Access to collateral Information**

Regarding access to WCCIS for MHA Assessments, all S12 Drs employed by SBUHB will be given read access to WCCIS to enable them to access information pertaining to the patient being assessed under the MHA 83. AMHP also have full access to WCCIS. Both organisations (SBUHB/CCOS) committed to reminding both the AMHP and the S12 Drs to discuss patient history and any collateral information prior to the assessment taking place who recognise the importance of an all Wales digital solution. The Health Board, in the letter sent on 3rd April 2024, (referenced on page of this letter) covered this important area.

- **Recording of MHA assessments**

All staff have been reminded (via letter circulated over email from the MHLD Service Group Medical Director and the MHLD Service Group Nurse Director), that they have a professional obligation and responsibility to record contemporaneously and to keep accurate records of all their interventions with all patients.

S12 Doctors have been reminded of this obligation by means of the letter circulated, and the inclusion within the training programme (as identified within the response to concern 1) of the requirement to make a record of the assessment made within the Mental Health Act Assessment, the outcome and plan. After discussion with CCOS it has been agreed that in relation to the Doctors recording Mental Health Act recommendations on client records for when they decline to recommend admission, the AMHP Assessment Form is being amended by CCOS to include a section for S12 Drs to make a direct entry to the notes. As soon as this is received the Health Board will implement it. If there is no IT access at the time of assessment this can be completed by the Doctor and added retrospectively to the notes.

Concern 3
"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. "

Swansea Bay University Health Board Response

The Mental Health and Learning Disability Service Group Learning and Development Team have in place a program of training and monitoring for WARRN training, which will ensure that the training levels are above 90% for staff working in the area. Since the inquest additional and bespoke training has been provided for clinical staff on Ward F and across the other 2 adult Mental Health inpatient wards. This was provided on 20th and 21st May 2024 and again on 4th and 5th June 2024. Following these additional dates, the current compliance for WARRN training for registered nursing staff on Ward F is 94% and the overall percentage for Clinical staff on Ward F is 96% (this includes psychology, Occupational Therapy and Psychiatry). It would not be possible to achieve 100% compliance due to staff absence (e.g. maternity leave) and staff turnover. Training compliance will be monitored by the Service Group Directors through a monthly performance meeting.

Concern 4

"During the inquest I heard that in 2021 [redacted] *parents (including the deceased, Kim) became concerned that their son was not receiving appropriate care and treatment from SBUHB in circumstances where* [redacted] *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* [redacted] *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* [redacted] *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 [redacted]) 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 [redacted] 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 [redacted] admission to Ward F. Both SBUHB internal investigations did not look at any aspect of [redacted] 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 [redacted] 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 [redacted] 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."

Swansea Bay University Health Board Response

Serious Incident Reviews in Mental Health and Learning Disability Service Group are undertaken in line with the NHS Executive National Policy on Patient Safety Incident Reporting and Management 2023. Within the policy a mental health homicide is when a homicide has been committed, and the alleged perpetrator has been in contact with primary, secondary or tertiary Mental Health Services within the last year. In these circumstances, the incident is considered to be a 'Must Report' and is reported to the NHS Executive as a National Reportable Incident.

In these circumstances a Serious Incident review is commissioned to look at the care of the patient. The process requires a strategy meeting where any immediate risks are identified and the actions needed to resolve them, the scope of the review is determined and any requirement for support of staff involved.

Following the strategy meeting, the review is undertaken by a trained investigator supported by clinicians who were not involved in the care of the patient. When a patient has died, the family are made aware of the review and asked if they would like to contribute to the scope of the review in line with the Duty of Candour Statutory Guidance 2023.

The final stage is that the review is presented to the Serious Incident Group chaired by the Medical Director for Mental Health & Learning Disabilities. The group is made up of clinicians from across Mental Health and Learning Disabilities Service Group where the learning identified is discussed and action(s) to improve the service allocated.

Complaints are managed via the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. This requires the investigation of all concerns to be recorded and an investigation undertaken into the care provided. Formal response to complaints, to families or carers, requires the consent of a patient. However, all concerns are investigated, regardless of consent, to gain assurance that the care provided was appropriate and identify any learning to take forward.

The outcome of a complaint investigation is that where learning is identified, actions are put in place to address the issues highlighted.

Both processes require a detailed review of the care provided to be undertaken, proportionate to the concerns identified.

The Regulations and Policy for the completion of serious incident reviews and complaints, while different, both processes can and do run alongside each other with shared outcomes and learning.

Although the external report findings had been shared with the Clinician referred to in the concern identified by the Coroner, the Health Board accepts it should have been shared with the Clinician involved in a more timely manner. The Health Board has reflected and reviewed its processes and will share clinical reviews, obtained to support the investigation of incidents and complaints, with the Clinicians involved within 7 working days. This will enable further discussions to take place and reflection undertaken in the care provided.

Review Commissioning and Purpose
As a commitment to ensure our internal processes remain robust, open to scrutiny, and are responsive, we commissioned a review by the Director of the Research, Development, Innovation, Improvement and Learning Hub of the governance in respect of the service's serious incident reviews.

The report provided a summary of the current processes established through this review and provided a number of recommendations which the Service Group Directors are set to review in July 2024 and prepare an implementation plan. One area of the Report focuses on is the Investigative process and recommendations around:-

- Focus on the role of the investigator, clinical advisors and the function of the report review meetings.
- Involvement of families and significant others
- Differentiating the levels of investigation and proportionate reviews

In addition, a focus on ongoing learning and improvement is included and this will ensure risks identified are addressed and followed up following a patient safety incident.

The Health Board accepts that the complaints made by the family in May 2021 were not addressed in a timely manner and outside of a co-ordinated approach. All complaints received by the Health Board are investigated under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) 2011 and Putting things Right Guidance on dealing with Complaints since April 2011.

In accordance with the requirements of the Regulations the Health Board's arrangements for the handling and investigation of concerns ensures that complaints are formally logged and acknowledged within the prescribed timescales of 5 working days. The Health Board ensures timely and full investigation of complaints in an open and transparent manner in line with Health Board values.

The Health Board ensures that the expectation of the complainant is met and that they are involved with the complaints process and kept fully updated with developments. All complainants are advised that they can seek support and assistance from Llais, the patient advocacy service. Complainants are provided with the contact details of the complaint investigator so that they may contact them at any time during the process.

Complainants will receive a timely and appropriate response within the bounds of receiving the appropriate consent. If a complainant raises a concern on behalf of a patient then appropriate consent is always sought. Under the NHS Concerns, Complaints & Redress Arrangements when a breach of duty of care is identified consideration is always undertaken in terms of an offer of redress if a qualifying liability is established.

The Health Board ensures that appropriate action is taken following the outcome of complaints investigations. Shared learning is of key importance to the Health Board in terms of learning and assurance to ensure that lessons are always learned from complaints.

The Health Board has reviewed the Standard Operating Protocol document which outlines the process of managing a complaint which has already been identified as an incident which ensures that incidents and complaints are managed together or individually within a timely manner ensuring that a full investigation is undertaken, and shared learning identified. If a complaint is received which raises issues that are not being considered within the incident process then a complaint will be opened and investigated fully. If a complaint raises the same concerns as the scope of the incident, then the complaint will be investigated as part of the incident process and will be fully addressed within the incident report. For assurance, please find attached the SOP document.

The Health Board is committed to ensuring a co-ordinated approach when an incident being investigated and when a concern is received by the Health Board. The Health Board's approach is to investigate once and to investigate well in accordance with the Regulations and the Duty of Candour Statutory Guidance. Going forward the Head of Concerns Assurance will carry out a quarterly review of SI investigations and complaints to ensure that a coordinated approach is being delivered and investigations are being progressed in line with process.

Concern 5

"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. "

Swansea Bay University Health Board Response

The core role of the Assertive Outreach Team (AOT) is to work with patients who are difficult to engage or demonstrate poor compliance with care & treatment plans. Referral to the AOT is not dependant on the patient giving consent to such referral. A monthly monitoring system is now in place to scrutinise the activity of the AOT. This includes recording the reason for any individual referral not being accepted by the team, the rationale for declining and a review and any actions in regards to this decision making. This will allow for more oversight; and a deeper understanding of any referrals not being accepted as part of our quality assurance process.

The AOT Operational policy was reviewed earlier this year and ratified in March 2024. This review included the amalgamation of the policies for both the Neath Port Talbot and Swansea AOT. The role, function and purpose of the AOT is clearly set out within the policy, including the process of referral and eligibility criteria. This has been recirculated to all referring clinicians and the wider teams.

In conclusion, we recognise the devastating impact of the events on the family, which was clearly evident to those staff who attended Court during the inquest. We would like to reiterate our Health Board's apology to the family and assure you that we have fully taken on board the recommendations you have made within the Regulation 28 Report.

We realise that these actions do not change what happened to Dr Harrison but hope this response provides you and the family with assurance that our failings have been properly recognised and addressed.

If you would like further information on the Health Board's response or actions taken, then we would be happy to assist you further.

Yours sincerely,

INTERIM CHIEF EXECUTIVE

DIRECTOR OF CORPORATE GOVERNANCE