Record of Inquest

Following an Inquest opened on the 19 April 2022 and an inquest hearing at Coroners Court, The Guildhall, Swansea, SA1 4PE on the 4 December 2023 heard before Kirsten Heaven in the coroner's area for Swansea and Neath Port Talbot

The following is the record of the inquest (including the statutory determination and, where required, findings).

1. Name of Deceased (if known)

   Nicholas Kim HARRISON

2. Medical cause of death

   1a Hypoxic-Ischaemic Brain Injury

   1b Traumatic Brain Injury

   1c

   II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

See attached narrative conclusion.

4. Conclusion of the Coroner as to the death

Unlawful Killing – see box 3

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **26 January 1954** **Preston, Lancashire**	
(b) Name and Surname of deceased **Nicholas Kim HARRISON**	
(c) Sex **Male**	(d) Maiden surname of woman who has married
(e) Date and place of death **9 April 2022** **University Hospital of Wales Heath Park Cardiff**	
(f) Occupation and usual address **Retired Consultant Husband of Jane Christina Harrison Retired Doctor** **Coniston Hall, Clydach, Swansea, SA6 5HG**	

Signature of

His Majesty's Assistant Coroner for Swansea and Neath Port Talbot, Kirsten Heaven

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Inquest into the death of Nicholas Kim Harrison

Narrative conclusion – 16 April 2024

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 reengaged 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.