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

Summary of the evidence – 16 April 2024

Nicolas Kim Harrison (who I will refer to as Kim) was declared deceased on 9 April 2022 at University Hospital of Wales, Cardiff. The cause of death was 1a blunt force head and neck injuries. On 12 March 2022 Kim was seriously assaulted by his son Daniel Harrison (who I shall refer to as Dan) 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. 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.

This inquest has spent a significant amount of time looking at the care and treatment of Dan from 2007 onwards and in a moment, I will be making detailed findings on this topic and the wider circumstances leading to Kim's death, but it is important to remember that this is an inquest into the death of Kim. I therefore commence my summing up by focusing on Kim and his life and long dedication to his chosen profession and to his family. It is clear from the evidence that I have heard that throughout his career Kim was a brilliant and highly respected doctor as well as a well-loved and dedicated husband and father. Many of the witnesses knew Kim at a professional level and it is clear the high regard in which he was held. Kim accepted a post as a chest consultant physician at

Morriston hospital in August 1994 and as a result he and his family moved to Swansea. This included Dr Jane Harrison his wife (who I shall refer to as Jane) who was also a doctor and his four sons Dan, Joe, Edmund, and James. On his arrival in Swansea, Kim dedicated himself to developing a modern respiratory department in Morriston Hospital. Kim's achievements during his working life are impressive and I have no doubt that Kim's work has made and continues to make a significant impact to improving the health and life outcomes for many people in the wider Swansea area as well as much further afield. Kim was also an enthusiastic teacher, and no doubt made a significant contribution to inspiring a generation of future doctors. Kim retired in 2019 but planned to complete ongoing research projects with colleagues at Morriston Hospital and Swansea University. It is clear from the pen portraits that I have heard that Kim's death, as well as the circumstances that led to his death, have had a lasting and devastating impact on his family, close friends, and colleagues.

As I said a moment ago, given the circumstances of how Kim came by his death this inquest has focussed on how it came to be that Kim's son Dan came to be so mentally unwell in March 2022 such that he carried out an attack on his father Kim that caused his death. This inquest has looked at Dan's state of mental health, his diagnosis and the care and treatment offered to and given to Dan by Swansea Bay University Health Board ('SBUHB') including how it came to be that Dan was able to abscond from Ward F and return to his family home as quickly as he did. I have received detailed written and documentary evidence covering the period 2007 onwards but there has been much more a detailed focus during the inquest on events from January 2021 to March 2022. I will touch upon and make more findings on the central issues that have been explored in this inquest.

In 2007 Dan experienced a psychotic episode which led to Dan being admitted to Cefn Coed hospital voluntarily during which time he was treated initially with Risperidone and then Olanzapine as an inpatient. This episode was initially diagnosed as a drug induced psychosis as Dan had been using a number of drugs, in particular cannabis, prior to this episode. Dan made a good recovery and was discharged and followed up in the outpatient clinic. Dan was briefly care managed and was followed up in outpatients in 2008 but he was removed from the care of Area 3 CMHT in 2009. Dan was seen by a consultant psychiatrist and other doctors and appears from the notes to have engaged well and had insight into his mental health. Dan's medical records indicate contact via outpatients through 2009 and 2010. Dans GP records indicate that he was seen by his doctors for review from 2008 onwards for his physical health needs and for example in 2010 Dan is recorded in the medical notes as saying that both his parents were supportive and there was positive reference again in 2011 to being supported by his family. In 2013 Dan became interested in furniture making and was accepted to a furniture making college in Oxford. There is reference in GP notes to a relapse in Dan's mental ill health in Oxford in 2014 which resulted in the GP in Oxford increasing his Olanzapine dose. By the end of the year Dan had lost weight and some of his symptoms of mental ill health had returned and this led to him being

seen by consultant psychiatrist Dr Maddock in outpatient clinic – for the first time on 6 August 2014. There is a detailed note made by Dr Maddox in the medical records for her first contact with Dan which clearly notes that Dan has been successfully managed on Olanzapine for the majority of his illness, but that Dan had become unwell with his symptoms worsening when he reduced his Olanzapine from 20mg to 2.5 mg. In the reviews over the next few years by Dr Maddox the diagnosis was noted to be chronic psychosis. Dan was largely symptom free although there were periods where he exhibited some psychotic symptoms, usually at times of stress but Dan had good insight into his illness. It is clear from the medical records that Dan's symptoms responded well to increases in Olanzapine. It is also clear that Dan developed a positive therapeutic relationship with Dr Maddock, which included using a small dose of diazepam for situations of stress, as Dan had experienced in a large award ceremony, he attended in 2017 which had caused him to experience thought broadcasting. It is also clear that Dan had insight into his condition and was able to implement good management skills for his symptoms and condition, he was willing to accept help, had a positive relationship with his family and there is no evidence of Dan displaying hostility, anger or violence in the medical records. The plan following Dan's last appointment with Dr Maddock, on the 4 September 2018, was for him to be seen again on the 4 December 2018 but there are no further entries in his medical records. Staff shortage resulted in greatly reduced availability of psychiatric appointments for patients under Dr Maddox. Dr Maddox then became unwell in 2019 and resigned from post in July 2019. Due to Dr Maddox's medical condition, she was unable to inform her patients of her imminent departure. Dan was then not followed up and started to self-wean off the Olanzapine. SUBHB have accepted in two letters send to Jane dated 8 & 9 November 2023 in response to the family's letter of concern sent to the Health Board in May 2021 that "*it appears he (Daniel) had been removed from the care of Area 3 CMHT in 2009 (it is unclear why or by whom). This contributed to the lack of continuity in care for Dan when Dr Maddock left" and "there was a failure to put in place adequate arrangements for Dan's follow up care. I am sincerely sorry that Dan did not receive the appropriate follow up appointments following Dr Maddock's departure, this is clearly not acceptable, and the Health Board has taken learning from this to ensure more robust procedures are in place*".

I find that the failure by SUBHB to put in place appropriate and timely follow up arrangements when Dr Maddox left caused Dan to become disengaged from services at his was vulnerable. This in turn led to Dan weaning himself off Olanzapine in an unmanaged and unmonitored way which then led to a return of Dan's psychotic symptoms and a deterioration in Dan's mental health to the point where Dan lost insight into his condition. Prior to 2018 and the departure of Dr Maddox, Dan had always engaged willingly with mental health services. I am therefore satisfied that Dan probably would have engaged with a suitable replacement for Dr Maddox had one been offered by SUBHB to Dan in a timely manner. If this had happened, I consider it likely that Dan's mental health would not have deteriorated in the way that it did. I therefore find that there was a failure by SUBHB to put in place

appropriate and timely follow up arrangements when Dr Maddox left and that this probably contributed to Kim's death.

I accept the evidence of Professor Shaw - the independent expert – who considered that when Dan was being seen by Dr Maddox he probably should have had a differential diagnosis of schizophrenia and that there should have been discussions around the risk of relapse, relapse prevention and contingency planning with discussion of the merits of a trial without medication. Dr Maddox was in effect well managing Dan, but his diagnosis should have been schizophrenia and there should have been a documented series of plans in place as indicated by Professor Shaw. It would clearly have been helpful to address this with Dan. In any event, Professor Donnelly viewed Dan's records in June 2020 as soon as there was contact with mental health services by Dan's family who were concerned. It is clear that certainly in the review of April 2021 - after his assessment of Dan in the police station on 27 April 2021 - Professor Donnelly was of opinion of Dan that "*the history suggests very strongly that this patient has suffered with symptoms highly suggestive of a schizophrenic illness*". I find that when looking at Dan's medical notes in June 2020 Professor Donnelly ought to have immediately realised that Dan was likely to be a schizophrenic who was off medication and relapsing and that a relapse plan needed to be put in place.

Between 2016 and 2019 Dan was a successful furniture maker winning awards, with some of his achievements captured on video, including the Howdens Rooser video and a video where Dan was interviewed about his work in November 2019 in Jermyn Street with John Smedly. Dan was also a Quest scholar. From 2018 for 18 months Ty Einon, which was part of the SUBHB community mental health team ('CMHT'), had begun cancelling Dan's appointments. I find that if Dan had been seen and engaged during this 18-month period he probably would have engaged with services, developed new therapeutic relationships, and remained on medication.

Between March - June 2020 Dan's parents and his brothers became very concerned that his psychotic symptoms had returned, and that Dan was now unwell. Dan had weaned himself off his medication and appeared unwell. Dan moved out of the family home in June 2020 and in July/August 2020 moved to a new workshop owned by someone who I will refer to as the landlord. Dan's parents came to learn about Dr Maddox's departure and so in June 2020 they contacted Ty Einon themselves speaking to the secretary of Professor Donnelly. A note of the call records Jane stating that she was concerned that Dan had stopped taking his medication and was paranoid and delusional and felt abandoned and had fixed ideas about people but also that Dan didn't know about the call and a request that Dan be reviewed but a request not to disclose the call to Dan or place it on Dan's notes. This was followed up by an e-mail to Ty Einon from Dan's parents which was send to Professor Donnelly by his secretary. The secretary knew Dan and had a good relationship with him. The email set out in

summary Dans mental health history, the fact that he had not been followed up following Dr Maddox's departure and that there had been a number of failed attempts by Dan, his GP and the parents to requests appointments from Ty Einon but these had not met with success and that in the family's view Dan's mental health had deteriorated over the previous 3 months which was suspected to be due to a reduction in the use of olanzapine. There was a reference to Dan's delusions which included having paranoid beliefs such as that the home computers were bugged, that he was being spied on at his site, that he suspects there were undercover operations at the site and that he was being harassed on social media. As a result, the concern was that Dan had declined from someone who had been recently operating at a high level socially and in his work (with a reference to an interview for John Smedley). Professor Donnelly told his secretary to speak to Dan about being lost to follow up and to offer an outpatient's appointment. A call was made to Dan on the 1 July 2020 to arrange an outpatient appointment, but Dan said he was busy and said he would ring the following week. A video call was arranged for the outpatient appointment on the 9 July 2020 with a voicemail left, but Dan did not attend. Meanwhile the family were e-mailed on 3 July 2020 and told that Professor Donnelly's advice was to speak to their GP. The parents were not told that Dan in fact had an appointment in Ty Einon. On 9 July 2020 when Dan did not attend, and Professor Donnelly made entries in the medical records summarising some of Dan's medical records which show that at this stage that Professor Donnelly understood how Dan had presented and been managed under Dr Maddox and his mental health history back to 2007. Professor Donnelly offered a remote appointment on the 29 July 2020. Up to this stage I find that Professor Donnelly's actions were appropriate.

When Dan was called the secretary days before the appointment at the end of July 2020 Dan stated he did not want an appointment. On this call Dan was angry described feeling felt let down by Ty Einon when he was ill a few months before and there is a reference to ringing Ty Einon repeatedly and they didn't get back to him. He was angry with his parents for not telling him that Dr Maddox had left. He describes his parents as toxic and that they should have helped him years ago. He also references positive things happening, including at work, not drinking alcohol, and not hallucinating. He stated he had no contact with his parents and was advised to take the secretary's direct phone number which he did and was advised to contact the secretary directly if he felt the need for follow up. He did not want follow-up with mental health services. A letter dated 29 July 2020 was sent by Professor Donnelly to Dan's GP stating that Dan had a well-documented history of chronic delusional disorder that in the past required antipsychotic medication but "*considering the patients communication with my secretary I will not plan to follow him up but obviously would be happy to see him at any point if requested*".

I accept the evidence of Professor Shaw that in her opinion more should have been done by Professor Donnelly. Dan should have been followed up by Professor Donnelly regularly irrespective of what

Dan had said to the secretary. It ought to have been obvious to Professor Donnelly that it was not appropriate to simply to leave the onus on Dan who was potentially relapsing and lacking insight into his condition to contact services of his own volition. Even at this early stage I consider there was the emergence of a tendency by Professor Donnelly to place significant weight on what Dan was saying with limited weight given to why he was being asked to see Dan in the first place i.e., the collateral information and concerns raised by the family. This crucial piece of the jigsaw is simply missing from the two letters sent to the GP by Professor Donnelly. This is exactly the sort of information that the GP needed to know to ensure there was adequate communication and understanding about Dan. The GP should also have been given more information about when to refer Dan back into services with a clear plan of action in the event if a deterioration (and / or concerns being raised by the family) which should have been shared with Dan's family. This should have been recorded centrally on PARIS so that there was a record for all professionals to see, from the AMPHs to the SUBHB crisis team. Instead, there are some limited written records made in the Ty Einon medical records. This was unsatisfactory, particularly for someone like Dan who had a long history of involvement with mental health services and indicates a lack of joined up thinking by Professor Donnelly. I find that if Dan has been assertively followed up, including attempts at visits in the community by a single person Dan probably would have engaged and developed a therapeutic and trusting relationship with Ty Einon staff.

Dan's family became increasingly concerned about what they perceived to be Dan's deteriorating mental health over the Christmas of 2020. Dan stayed in his workshop and was visited by his brothers but not his parents as relations had broken down with them, As a result, the Harrisons contacted their GP with their concerns and outlined Dan's psychosis, auditory hallucinations, off medication for 18 months, in accommodation with no running water, selling things to move to Tasmania. The GP contacted Dan and he was irate, said he was fine, explained his consultant was now a lawyer and Dan accused the GP and the practice of poisoning him with medication and he screamed and swore down the phone and hung up. The GP considered Dan's demeanour was strange and the GP formed the view that Dan was acting out of character and that he was showing signs of psychosis and that he lacked insight. He considered that the desire to move to Tasmania was not rational and also indicated a lack of insight. The GP came to this view having known Dan since 2007. The Harrisons and the GP contacted the single point of access ('SPOA') (after the Harrison's had been told only the GP could access the SPOA). The GP told the SPOA about how Dan was acting out of character. There is a note of this conversation in the GP records. There is also a note in the SPOA records showing that the GP made clear that he had concerns about Dan that he was paranoid aggressive and shouting at him and refusing to have an assessment and that the GP was unwilling to undertake a visit on Dan as he would not feel safe. The GP also reported that Dan has been under Dr Maddox, was off his medication and

discharged by Professors Donnelley, was living with no electric or running water and was washing in a stream.

Will Johnson, a social worker and AMPH employed by City and County of Swansea ('CCOS'), was notified of this SPOA request on 18 January 2021 indicating that Dan's family were requesting a mental health act assessment under the Mental Health Act 1983 ('MHA') as the Nearest Relative ('NR'). Will Johnson was an experienced AMPH with some 20 years of experience and had attended and arranged many mental health assessments. At this time the records show that the SPOA was consulting with WJ about what to do with the concerns that were coming in from the family and the GP. I therefore find that from the outset Will Johnson knew the gist of the concerns held by Dan's GP and that the GP was so concerned for his own safety that he was not assess Dan in person.

Will Johnson spoke to Kim as the NR and he provided a brief history and described the family's concern around Dan behaving out of character and their concern that this indicated that his mental ill health had relapsed. Will Johnson states he then considered Dan's PARIS records. Will Johnson then visited Dan on 19 January 2021 with AMPH Alison Cole. This was followed by a further two visits on 20 January and 28 January 2021 by Will Johnson alone. On 21 January 2021 in an email to the family WJ states, '*To me, he presents as what would be stereotypically described as "new age" or "alternative" (though increasingly common lifestyle choices) – would you say that this reflects Dan over the years or is this something that has developed relatively recently/become more pronounced recently*?' The email was firmly responded to by the Harrisons in an email of 24 January 2021 to Will Johnson which set out Dan's history all the concerns held by the Harrison family regarding Dan's mental health and photographs were provided of Dan's living conditions (which the family descried as appalling). I quote from this e-mail:

"*As we have explained, around March 2020 Dan stopped taking Olanzapine, the anti-psychotic medication he had been on for 13 years. Over the past 10 months, we and his wider family have observed significant changes in both his personality and lifestyle, as described in my earlier email. These have been profound changes – Dan has gone from being a gentle, patient, caring and thoughtful person to an impatient man with a short temper, reluctance to respond to enquiries and a distrust of most people around him*".

The email attached to this document also referred to 2 close long term friends and Dan's three brother who were willing to provide corporative' independent' information about Dan and gave many examples of Dan's delusions.

Will Johnson was called by Dan's GP on 2 February 2021, and I find that the GP made clear to WJ that he considered that Dan was mentally unwell and was suffering from a mental health relapse and not making a lifestyle choice. However, this information was not documented by Will Johnson when

it should have been. There are further communications to Will Johnson from the Harrisons on a similar themes, with a link sent to the John Smedley video of Dan talking about his work in 2019. There was then a final visit to Dan by Will Johnson and Dr Sian Heke a consultant psychiatrist on 9 February 2021 to conduct what was described to the family as formal assessment under the MHA 1983. The joint view taken by Will Johnson and Dr Heke was that Dan did not meet the criteria for detention under the MHA 1983 and that Dan was keen to pursue an alternative lifestyle and that there was no evidence that Dan's current lifestyle choices were influenced by any form of mental illness. The final AMPH assessment documentation of 9 February 2021 was countersigned by senior AMPH manager Nicola Mort on 13 February 2021. I have heard from Professor Donnelly that Will Johnson spoke with Professor Donnelly on three occasions after his visits and queried with him whether Dan may be masking and that he reported on two occasions that there was no evidence of psychotic symptoms. Will Johnson did not speak with Professor Donnelly immediately before or after the attendance on the 9 February 2020 with Dr Heke.

I know turn to some more detailed findings in relation to February 2021.

On receiving a request for a mental health assessment a local social services authority must comply with section 13 of the MHA 1983. In summary they must make arrangement for an AMPH:

*"…. to consider the patient's case with a view to making an application for his admission to hospital; and if in any such case **[**that professional**]** decides not to make an application he shall inform the nearest relative of his reasons in writing*" (s.13(4))

This may include interviewing the patient because as per s13(2):

"*Before making an application for the admission of a patient to hospital an [approved mental health professional] shall interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need*".

The Mental Heal Code of Practice for Wales ('MHCOP') states as follows in relation to the AMPH (*inter alia*):

"14.43 Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act. The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act……

Consultation with other people
14.58 Although there are specific requirements to consult the nearest relative, the value of involving other people in the decision-making process should be recognised, particularly the patient's carers, family members and advocates, who are often able to provide a particular perspective on the patient's circumstances. In so far as the urgency of the case allows, AMHPs should consider consulting with other relevant relatives, carers or friends and should take their views into account.

14.61 AMHPs should also consult wherever possible with other people who have been involved with the patient's care, including their care co-ordinator if they have one."

On first being contacted by SPOA Will Johnson was on notice that Dan's GP had the concerns I have already indicated but only in summary form. Will Johnson did have detailed collateral information from Dan's parents but given the apparent conflict between Dan and his parents, Will Johnson should have obtained further collateral information from Dan's friends and brothers as suggested by Dan's parents prior to seeing Dan as required the MHCOP. Will Johnson should also have contacted Dan's GP directly to get more information. This should have happened before any visit to Dan. In failing to do this at the earliest opportunity Will Johnson did not ensure he had the opinion of a medical professional and others who knew Dan to inform all his assessments as required the MHCOP

I am also not satisfied that Will Johnson had a full and adequate conversation with Professor Donnelly about Dan at any stage prior to and following his final assessment of Dan. There is no mention by Will Johnson that he spoke to Professor Donnelly in his witness statement, and he could not remember speaking to him when I asked him in questioning. If any conversation did take place, I consider it likely to have been little more than cursory and that Professor Donnelly did not give Will Johnson a full and accurate account of Dan's full mental health history. I also note that the health and safety section of the form completed by Will Johnson on 9 February 2021 after the mental health act assessment is the only part dealing with Dan's past medical history and it is inaccurate and incomplete. This section focuses on the psychotic episode in 2008 which is recorded as being related to use of illicit drugs as a result of 'rave' attendance. There is a reference to Dan being care coordinated and then managed in out-patients. The form then states "*was on anti-psychotics until he stopped these approx1 year ago'*. I consider it likely that this is a summary of information provided by Kim Harrison and possibly by Dan. There is a no reference in the form of 9 February 2021 to any of Dans mental health history in more recent times and more crucially when he was being seen by Dr Maddox and the crucial fact that his condition had been managed successfully on olanzapine over 10 years with a relapse when the dosage was reduced. There is no reference to Dan's current diagnosis. I find that if Professor Donnelly had given this information to Will Johnson, it would have been documented on this section of the form. In any event Professor Donnelly would have been of limited use to Will Johnson as unlike the GP he didn't know Dan.

In any event, Will Johnson should not have relied on Professor Donnelly for a summary of Dan's medical history. Will Johnson should have read Dan's medical and AMPH records including the most recent ones. Will Johnson had received a detailed history and concerns from Dan's parents some of which I have already summarised. The document sets out at length what is a substantial deterioration in function of Dan. It also sets out the family's concerns and the concerns held by Dan's brothers. The consultant psychiatrist, Dr Haynes, who was asked by SUBHB to provide an internal expert opinion on this period of time stated that '*the symptoms described indicate a psychotic relapse'*. Dr Hayes was talking about a document sent to SUBHB by the Harrisons slightly later in Mid-February 2021 but this document was mirrored in the document sent to Will Johnson in January 2021. Given the collateral history contained evidence indicating a psychotic relapse, it was vitally important that Will Johnson scrutinise Dan's medical notes in the absence of consulting Dans GP to verify and place in context what he was being told by Dan's family particularly where a potential conflict was being indicated between Dan and his parents. It was also vitally important that Will Johnson watch the video of Dan when he was well and seek to verify and fact check what Dan's parents were saying. Will Johnson accepted not watching the Smedley video. He should clearly have watched this video as part of his evidence gathering duties.

I also find that Will Johnson did not read all Dan's medical records. Will Johnson told me in questioning that his starting point would have been the records that were available to him from around the point of his admission because that would have given some explanation as to how Dan was at that time. That was in 2007. Will Johnson claimed to have the looked at more recent records from Dr Maddox but when I took him to some specific examples including, for example, the very detailed Dr Maddox letter from August 2014, Will Johnson couldn't remember seeing that letter before seeing Dan but he did remember seeing it after the incident. There are other examples where Will Johnson did not know if he had seen a medical record. For example, he didn't think he was aware from the notes that Dan relapsed when he came of Olanzapine. Will Johnson accepted in evidence that he did not look at the medical file beyond PARIS and so he did not see e.g., the letter from the family of June 2020 to Professor Donnelly. In Will Johnson's witness statement made on 22 June 2022 there is only one reference to a diagnosis and that is to drug induced psychosis following the admission to Cefn Coed in 2004. This was not the current diagnosis for when Will Johnson was seeing Dan (which was chronic psychic disorder). I therefore find that Will Johnson assessed Dan on the erroneous assumption that Dan's mental health illness was connected to drug taking rather than an underlying diagnosed psychotic disorder not related to drugs as Will Johnson had failed to adequately appraise himself of all available collateral and medical information. I find that in doing so in February 2021 Will Johnson did not act in accordance with his duties under the MHCOP. I further find this failure to be significant because Will Johnson was an experienced AMPH but also because the result was that these failures in information gathering led to flaws in the assessment of Dan in February 2021. First,

because they were inappropriately influenced by an assumption around drug taking which I consider likely fed into an erroneous assumption that Dan simply making a lifestyle choice with which his parents disagreed and second this led to a failure to place significant or indeed any real weight on the collateral information.

In terms of Will Johnsons assessments, I find that Will Johnson adopted an approach which relied almost exclusively on how Dan presented, where Dan was allowed to dominate and control the encounters. I find there was an over-reliance on what Dan was saying and a lack a critical thinking and testing of Dan's account and presentation. For example, I find there was no critical thinking by Will Johnson about why Dan had become distanced from his parents when the records showed he had had a long and supportive relationship with them for the vast majority of his life, there was no consideration that Dan might be exhibiting a lack insight into his mental health which had not been present before, there was no critical thinking about Dan's living conditions. There was no critical thinking of the sort engaged in by Gaye Kavanagh a mental health worker who saw Dan 4 weeks later. Will Johnson was as experienced as Gayle Kavanagh and I find that even though she saw Dan after WJ's last visit, it is unlikely that Dan would have been profoundly different given what I have been told by the Jane and Edmund Harrison about Dan's living conditions and presentation in January 2021.

I therefore find that there was evidence before Will Johnson indicating that Dan was experiencing relapse in his mental health. Dan was behaving out of character and in a way consistent with what his parents were saying. For example, Dan was initially abusive, prickly, and irritable and did not like the fact that Will Johnson had a file with him when previously he had always been open to engaging with professionals. Dan was talking about going to Tasmania in the middle of the Covid -19 pandemic when he had no money, but Will Johnson did not consider this to be a red flag. Dan was angry about his father leaving the NHS in COVID. Dan did not appear to accept that he was unwell or needed medication when the records clearly demonstrated that he had a diagnosed mental illness that required very careful management with olanzapine which Dan had always accepted and into which he had insight. Dan was expressing being let down by services (again something not seen in the notes previously) and it is recorded that there were '*fleeting instances where he felt slightly paranoid'*. WJ stated to the family in an email on 21 January 2021 that "*what I am quickly learning is that if I ask too many questions this seems to unsettle Daniel however if he is allowed to express himself he talks quite freely*". Dan did also present as willing to engage and show people around his workshop in later visits. However, Will Johnson accepted in questioning in the inquest that he did not tackle Dan about some of his specific delusions which indicated emerging psychosis such as why he thought his parents were fascists, why he thought there was a large-scale drug ring on the site, why he thought his father was working for the government manufacturing coal within a laboratory for financial gain. These

were all delusional beliefs in the collateral information sent to Will Johnson. I therefore find that in all the assessments of Dan in February 2021 there was a failure to challenge Dan on his specific psychotic symptoms thus facilitating Dan's ability to mask his psychotic symptoms. This is a theme which continues throughout all Dan's assessment. I also find that Will Johnson missed many of the indicators of Dan's mental illness and did not appear to appreciate that he might be being controlled or manipulated by Dan.

I find that prior to Dr. Heke's attendance Will Johnson had already formed a fixed view that Dan's decisions were motivated by wanting to lead an alternative lifestyle and not in any way influenced by mental illness. I find that this was a wholly wrong and unjustified view given the collateral information. However, in terms of procedure at any point after the first few visits it was entirely within Will Johnson's remit to refuse to carry out an assessment under the MHA 1983 as requested by the NR or to attend on Dan with another doctor to further assess Dan pursuant to local authority duty to consider Dan under s.l3 of the Mental Health Act 1983 ('MHA 83'). However, this is not what happened. As stated by Dr Heke when she was contacted, she thought the appropriate course was to complete a formal Mental Health Act assessment. I agree. This was the only appropriate course of action at this stage given the nature of the concerns being raised by Dan's parents. This is what was in fact what was purportedly undertaken. Will Johnson told the family that he was doing a formal mental health act assessment, and his intention is indicated in the AMPH form he completed after the assessment. However, this was not an emergency scenario and so this meant that the requirements of section 2 of the MHA 83 had to be complied with. This is not complex law or procedure. This is basic mental health law and practice that I am satisfied that Will Johnson, Alison Cole, Nicola Mort (who did in fact did arrange a mental health act assessment compliant with MHA 83 on 27 April 2021) and even Dr. Heke would have been aware of this. Consequently, I find that the mental health act assessment organised by Will Johnson on 9 February 2021 was not conducted in compliance with the MHA 1983 as there was only one attending doctor when there should have been two. I prefer the opinion of Professor Shaw on this point.

Under the system in which Dr Heke operated as a locum s.12 doctor, Dr Heke did not have access to Dan's medical records. This was a systemic deficiency on the part of SUBHB which prevented Dr Heke acting in complicate with the MHCOP which contains a mandatory requirement for assessing doctors conducting a medical examination to consider all available relevant clinical information (para 14.64). Dr Heke was therefore reliant on Will Johnson to provide a summary of the medical history to mitigate against the deficiency in the system being operated at the time by SUBHB, but this did not happen for the reasons set out above. I accept Professor Shaw's opinion here which is that this was inadequate. It was also inadequate that Dr Heke did not make any record of her assessment on Dan.

When Dr Heke attended on 9 February 2021, I find that Will Johnsons assumptions likely influenced the briefing that was given to Dr Heke and I consider it unlikely that Dr Heke was given any detail about Dan's extensive mental health history and management under Dr Maddox or that she understood the full nature of the concerns of Dan's parents. Dr Heke described being shown around Dan's workshop and outside and painted a picture of Dan being allowed to dominate the conversation with standard questions being asked. I find that Dr Heke would not have challenged Dan on his specific delusion beliefs as I find she did not know about them. I also find that it is unlikely that Dr Heke appreciated the significance of how Dan presented and the conflict with his historical presentation. For example, I find Dr Heke would not have appreciated the significance of Dan's hostility to his parents, his unwillingness to engage with MH services, Dan's choice as to how he wanted to live, the state of Dan's living conditions. Consequently, I find that Dr Heke was simply not in a position to assess and understand the significance of what she saw when she attended on Dan and this fundamentally undermined her ability to adequately assess Dan in any meaningful way. Dr Heke was simply left with assessing Dan at face value.

From all the evidence that I have considered it is clear that Dan was able to talk in a very composed and intelligent way to professionals including when he was mentally unwell. I also note that in some of the attendances with Will Johnson Dan was cooperative and friendly. I therefore have no doubt that at times when Will Johnson and Dr Heke visited Dan, he was able to speak in a convincing and plausible manner which would have provided some reassurance to these professionals. However, I have also heard how experienced AMPHs, and consultant psychiatrists armed with all the medical history and collateral information are trained to be on guard for a masking of symptoms by an intelligent unwell individual and I have heard that they are trained to ask questions aimed at eliciting signs of acute mental illness. As I have already found, this did not happen because there was insufficient knowledge and focus on Dan's reported psychotic beliefs in February 2021.

I find that the AMPH Assessment document that was in fact completed by Will Johnson on 9 February 2021 was wholly inadequate and inaccurate. First, the reason for the mental health assessment was an application by the NR, this was documented but then nowhere in the form is the full detail of the reason for the request set out, in other words the concerns of the Harrisons are not properly documented. Instead, the reason for the NR request was presented as being a conflict between parents, who though their son was mentally unwell in the context of historic drug usage, and an adult son who wanted to lead an 'alternative lifestyle'. This was a gross mischaracterisation of Dan's mental health background history and the reason for the request. Second, the finding that '*there is was no evidence that his / Dan's lifestyle choice current were influenced by mental illnes*s' was simply not supported by all the evidence available to Will Johnson. The collateral evidence suggested the exact reverse. This finding is clear evidence on the disproportionate weight that Will Johnson placed on Dan's account

whilst placing insufficient weight on the collateral information. Third, conclusions were formed which were simply unsupported by the evidence or made on partial evidence. For example, the conclusion that Dan does not present as neglecting himself was made without sight of evidence of how Dan normally presented when he was well, including on the Smedley video which Will Johnson did not view, and without reference to Dan's living conditions, which were not properly inspected by Will Johnson.

I find that by 9 February 2021 there was a significant amount of evidence available to professionals to corroborate what Dan's parents were saying namely that Dan was suffering from a relapse of his chronic delusional disorder which was untreated. I find that this ought to have been clearly identified in February 2021 by Will Johnson, Alison Cole and Dr Heke and clearly documented with a plan of care put in place, with or without Dan's consent. I find there should have been referral back to Ty Einon and the CMHT for consideration of: (i) assessment for admission to secondary mental health care and/ or (ii) some other form of robust engagement whether or not Dan explicitly consented; (iii) further attempts at assessment and engagement by Professor Donnelly.

I am unable to say whether the plan care for Dan ought to have included admitting Dan to hospital under the MHA 1983 either voluntarily or against his will (i.e., detaining / sectioning Dan) and indeed whether Dan met the criteria for detention under the MHA 1983 in February 2021. This is because the assessments carried out on Dan at this time were fatally flawed and compromised by the matters that I have already identified. As I have already indicated there were clear signs that Dan was suffering from a mental health release in February 2021, but the flawed assessments meant that psychotic beliefs that were likely present were not explored. In terms of risk there was no evidence at this stage that Dan presented a risk to others, but the extent of Dan's self-neglect was also not adequately appreciated and recorded.

Dan's parents were not content with the outcome of the Will Johnson/Dr Heke assessment and contacted the AMPH service to raise their concerns. Dr Harrison called the AMPH service to express her dissatisfaction. Unhappy with the response the Harrisons relied on their personal contacts within senior management of the health board. On 14 February 2021 they were communicating with David Roberts Service Group Director Mental Health and Learning Disabilities about their concerns about the management of Dan's psychotic illness. A detailed document was attached which summarised Dans psychiatric history and the family's concerns about what had taken place. This document raises many issues but key amongst them are the family's concerns around the failure of the assessments in February 2021 to gather sufficient colleterial information and Dan's ability to hide his psychotic symptoms and the concern that Dan had relapsed, was extremely vulnerable and unwell and requests and suggestions for help including regular review, support and monitoring of Dan by skilled

professionals to detect any further deterioration so that appropriate care can be provided to maintain his future well-being. There was also the concern around compliance with the MHA 83. In taking this action the Harrison family were taking entirely logical and understandable steps in relation to getting assistance for Dan. The Harrison's were by this stage in very difficult position. They were seeking to get help for their adult son who they knew was very mentally unwell. However, the difficulty was that by this stage Dan was so unwell that he had lost insight into his illness and so was clearly not consenting to treatment and in his mind was in conflict with his parents. This clearly also presented challenges for SBUHB.

I consider that from this point on a number of senior employees in SBUHB did their best over many months to assist the Harrisons. However, I have come to the clear conclusion that from the point at which senior members of SUBHB were contacted by the Harrisons a defensive mindset did began to take root within both the SUBHB and the CCOS AMPH service which prevented both organisations from honestly and critically appraising their involvement in Dans care.

Unbeknown to the Harrisons family there was a professionals meeting on 22 February 2021 in response to their communication and concerns sent to SUBHB in mid-February 2021. The meeting was attended by Dr Peter Donnelly, Mike Evans, Lead Nurse MH division Martyn Reeve, CMHT manager and Will Johnson and the notes clearly suggest a defensive tone was adopted. Will Johnson was the only one to have seen and assessed Dan and so reliance had to be placed on his assessments on Dan's presentation by those at this meeting, including Professor Donnelly. However, this meeting was an opportunity for the assessment and conclusions of 9 February 2020 to be robustly tested and challenged in line with Dan's medical history with a further look being given at the history from the family. I am not satisfied that this happened. Rather it appears that the meeting proceeded on the basis that Will Johnson and Dr. Heke's assessment and the conclusions of the 9 February 2021 were accurate and correct. Will Johnson tells the meeting '*there were no overt signs of psychosis present on interview, no evidence of DH having taken illicit substances'*. I find the reference to illicit substances as telling as it further indicates that at this stage Will Johnson's erroneous thinking that Dan's illness was connected to drug taking. There is no evidence that this was challenged by Professor Donnelly, or that anyone raised the conflict between what Will Johnson had observed and Dan's apparent lack of insight as compared to Dan's medical history. Will Johnson also stated *'that reasonable attempts had been made to illicit information from the family to inform the assessment'* which was not accurate as no attempt had been made by Will Johnson to contact Dan's brothers as well as the other collateral information discussed above. There is also no evidence that anyone including Professor Donnelly queried what other collateral information had been sought to test and corroborate what Dan and separately his parents were saying. I consider that there were obvious queries that should have raised with Will Johnson and the fact that this did not happen leads me to find that the meeting was focussed

on reinforcing the decisions that had already been made rather than critically assessing whether any mistakes had in fact been thinking about what more could be done. There is no recorded acknowledgement in this meeting that Dan may have relapsed and become mentally unwell given he was not taking olanzapine which it was clear he needed from the medical notes and that some plan needed to be put in place to try and engage Dan to prevent further deterioration if possible. There was no recognition that the MHA carried out by WJ and Dr Heke did not comply with the MHA 83 when it plainly did not. There was no discussion of whether the MHCOP permitted information to be taken from the family, which it does, and which Professor Shaw told me was good practice - and how this ought to happen moving forward. All the evidence suggests the collateral information was simply ignored. The meeting concludes that '*Routes to re-referral would be through the GP or another request for MHA assessment (with reasonable grounds).. and There is a limit to what the wider CMHT can do within the confines on the law (MHA) to support DH without his express consent. If the situation changes or deteriorates these can be considered'*.

This was an unsatisfactory conclusion. I find that Dan should have been offered multiple further outpatients appointment ('OPA') by Professor Donnelly and there should have been an agreed plan set down for assertive engagement by the CMHT of Dan over a sustained period of time. I was told that such a service does exist within SUBHB. Professor Donnelly told me that its use was contingent upon the patient consenting to receive assertive outreach under secondary care. If it is the case, it is concerning is it means there is a serious gap in the care being offered by SUBHB to the most mentally unwell and disengaged patients in their jurisdiction. I have heard other evidence including from Professor Shaw which suggests that Trusts can and do routinely undertake visits in the community on hard to engage and unwell patients and indeed I heard other evidence in this inquest to suggest that this facility does exist in the Swansea area. In any event, those present in this meeting could have agreed that given the collateral information and medical history Dan required assertive outreach from the CMHT from a single person in the form of regular visits to try and get Dan to engage and to provide an opportunity to observe Dan. This should have been an outcome from this meeting.

I find that if this had happened it is possible first that Dan would have engaged as he had a history of engaging and did to some extent engage with Will Johnson and Gayle Kavanagh. I also find that assertive outreach at this point by a single person would have quickly revealed the extent of Dan's mental ill-health and his deterioration at a time when his paranoia and his volatility were clearly increasing. This is in fact what happened when Gayle Kavanagh did visit Dan on the 8 March 2021 when she immediately identified the extent of Dan's mental health deterioration and then on the second visit on 24 March 2021 when she visited Dan with 2 homelessness workers and Dan was very agitated and edgy and when spoken to he became more anxious and agitated and so Gayle Kavanagh decided to leave as she did not feel safe remaining there. I find that this would have placed the CMHT

and Professor Donnelly in much better position to understand the true picture in relation to Dan much earlier which would have in turn informed their subsequent assessments of Dan. I find that in all likelihood this possibly would have resulted in Dan receiving the care and treatment he needed much sooner than March 2022.

Dan was eventually offered an OPA by Professor Donnelly for 12th March 2021 but only after an email was sent by Kim raising further concerns about Dan who had had an argument with his landlord and was paranoid. Due to confidentiality this could not be shared with the Harrisons. I consider this was appropriate in the circumstances. Prior to this assessment Professor Donnelly was not aware that on 6 March 2021 Dan turns up at Coniston Hall and was threatening and abuse to his family and the police were called, that the Harrisons had a Zoom meeting with Richard Maggs, Medical Director, and David Roberts on 9 March 2021 where they set out all their concerns about Dan. Professor Donnelly did not see the detailed letter of concern dated 8 March 2021 which set out in writing the concerns that were raised in the meeting on the 9 March 2021. Richard Maggs told me his role was to feedback information to Professor Donnelly so I can only conclude there was a serious failure by SUBHB to share colleterial information to the treating psychiatrist Professor Donnelly. Professor Donnelly was aware that Dan was visited by Gayle Kavanagh on 8 March 2021 and had seen her assessment where she extensively documented evidence of paranoia and guarded behaviour by Dan and evidence of self-neglect and her view that "*Dan is a talented and independent man who has deteriorated enormously since stopping his anti-psychotics*".

On 12 March 2021 Dan attended on Professor Donnelly and reported to his brothers that he got on well and shared his thoughts However, the medical notes suggested Dan was annoyed at Dr Maddox's departure which made him difficult to interview, didn't want information shared with his parents and did not want follow-up. There is no evidence that Professor Donnelly explored Dan's paranoid delusions as reported by the family and the GP despite Dan clearly displaying indicators of paranoia in the notes. There is no evidence that he properly explored the findings of Gayle Kavanagh. I find this resulted in a flawed assessment that facilitated Dan to mask his symptoms. After a negotiation it was agreed that OPA would be left open for see on symptom. I agree with both Dr Haynes and Professor Shaw that this was not appropriate in view of the collateral history that was known to Professor Donnelly and that it was not appropriate to put the onus to seek help a person who was angry and probably lacking in insight. Particularly where this route had not worked in the summer of 2020. I agree with Dr Haynes that Professor Donnelly placed too much weight on Dan's presentation at interview. Again, I find it is significant that when recounting Dan's mental health history in the letter to the GP there is no reference to collateral information and what had been occurring previously in the recent history with Dan's parents raising concerns and the summary of Dan's medical history is incorrect. This indicated a lack of focus and attention by Professor Donnelly on the detail of Dan's

actual medical history and collateral information which I find was probably given no weight. I find that once again at this stage a plan of assertive engagement should have been set down by the CMHT to visit Dan and to try and engage him with a view to developing a therapeutic relationship.

On 22 March 2021 Gayle Kavanagh sent further communication to Professor Donnelly's secretary indicating Dan was to be evicted by his landlord and displayed aggressive behaviour to him. It was known clear to SUBHB that Dan was to become homeless. On 25 March 2021 the Harrisons and Edmund had a second meeting with Richard Maggs and David Roberts. Again, there were no official notes of this meeting. The notes made later by Edmund Harrison on 28 July 2021 where he states that he told those at the meeting that without support or treatment Dan was in danger of attacking or killing someone. Neither Richard Maggs nor David Roberts could remember this being said at the time and Professor Donnelly could not remember being told this by Richard Maggs. They considered that they would have remembered if it had been said given the seriousness of the risk being conveyed. I find that Edmund's recollection of the meeting was accurate and that he did state this. Edmund had already made a reference to Alison Cole about his concerns that Dan may stab someone, and this is documented by Alison Cole on 31 March 2021 and so it is clear that by this date Edmund was concerned about Dan posing a serious risk to someone's life. I have received extensive email disclosure and I have not seen any heard evidence to suggest that this information was shared with Professor Donnelly either at this stage or when it was later documented in an e-mail from Edmund on 28 July 2021. This was a significant failure by senior managers in SUBHB who were on notice that Dan may pose a risk to someone life but did nothing with that information.

On 30 March 2021 Dan was arrested following an altercation with his landlord who sustained a serious injury to his finger.

On 31st March 2021 the Harrisons spoke to Alison Cole requested an assessment under the MHA 83 of Dan as the NR. They requested another MHA due to due to Dan becoming increasingly violent, paranoid and recently threatening to them which required the Police being called. Alison Cole was informed that Dan had assaulted his landlord and was in police custody and had been presenting as being aggressive, delusional, psychotic and paranoid and threatening to his parents and the police had been called, that his parents had concocted the Covid-19 situation that he believed his phone had been hacked along with beliefs around corrupt fraud, that he had paranoid beliefs that his Landlord was trying to blackmail him. Jane requested that Alison Cole contact Dan's Landlord, the Homeless Outreach Team, Dan's GP, Dan's brother, and the local vicar.

Alison Cole then began collating various information about Dan. This included evidence that Dan had been assessed in custody twice by custody nurses who considered he had capacity and insight into his

situation and there no evidence of paranoia or thought disorder and Dan has been engaging with Police Officers and the assessing professionals. Some information was also provided about the offence. Alison Cole spoke to Professor Donnelly who confirmed the outcome of the OPA on 12 March 2021 and Alison Cole states "*It was agreed that as Daniel had been assessed in the custody suite that there was inadequate information to suggest a need for a further MHA assessment at that point*." Alison Cole then had a call with Dan's brother Edmund who explained about Dan having paranoid beliefs about the police, drug cartels and hells angels. Edmund advised that Dan's paranoia 'focuses on different people', and that Dan used to have a positive relationship with his parents. He advised that Dan had not attacked his parents. He expressed concerns with regard to the safety of Dan and also the safety of others. He advised that Dan '*could stab someone'*. He also referenced paranoid beliefs held by Dan.

On 31 March 2021 Alison Cole spoke to Professor Donnelly on a number of occasions. It appears that initially Professor Donnelly decided that an MHA would not be undertaken whilst Dan was in custody given the assessment of the custody nurse, it appears that Professor Donnelly then changed his mind considering that an second assessment should happen in custody but by the custody nurse/criminal justice nurse but when they refused and following further discussion with the AMPH service it was decided that Dan would be offered an OPA on 1 April. Alison Cole states

"*I also had a discussion with my AMHP colleagues and a further discussion was had with Professor Donnelly. We agreed that Daniel would be offered an appointment with Professor Donnelly in the first instance, in accordance with least restrictive principles as set out in the MHA Codes of Practice for Wales and is defined as "services should be delivered in line with the presumption of capacity, be the least restrictive option, serve a person's best interest and maximise independence*."

Professor Donnelly was unwilling to attend on Dan in the community as by this stage he was concerned that Dan posed a risk to his safety and that of any attending mental health professional.

As I have indicated the legal duty under s.13(4) of the MHA 1983 to consider a NR request and the patients case falls on the local authority and the AMPH not the Doctor. It was therefore Alison Cole's duty to ensure that she complied with s.13 of the MHA in considering the Harrison's request and for her to make the decision on assessment and admission. Alison Cole did not speak to Gayle Kavanagh, the Vicar or Dan's GP before reaching a decision not to undertake a mental health act assessment on Dan in custody as requested by the NR. The only information she had was an assessment by Professor Donnelly on 12 March 2021 which was before the altercation with the landlord and arrest and custody nurse assessment who had not been spoken to directly and who arguably had very limited collateral information and quite possibly no understanding of the full medical history. Alison Cole did not interview Dan in custody as per 13(2) MHA 1983. Even if this is not a mandatory requirement in the information gathering phase, I find it was not appropriate to rely on and or delegate the AMPH duty to

a custody nurse in circumstances where that nurse was not under the same duties as the AMPH (and clearly had limited or no access to collateral information). I find that the decision not to conduct a mental health act assessment or even interview Dan in custody was unreasonable and inappropriate and not in compliance with s.13 of the MHA 83 because it cannot be said that Alison Cole adequately considered Dan's case pursuant to s.13(4) MHA 83.

Dr Haynes describes the incident with the landlord it in the following way "*new development of aggressive behaviour (with no history of violence) it appears evidence that psychosis was deteriorating*". Professor Donnelly stated to me in evidence that at this stage he had appreciated and not ruled out that the altercation with the landlord was a potential sign of escalation in Dan's psychotic illness, that perhaps Dan had delusions beliefs about the landlord and there may have been an escalation from verbal aggression to direct violent action but that he didn't assess Dan in the police station as he had been seen twice by the custody nurse and not considered to be mentally unwell and had capacity but Professor Donnelly stated that he was never asked to carry out a mental health act assessment in custody. Professor Donnelly also states he didn't consider the risks that might arise if Dan was released from custody as that was a job for the custody nurse. I find that Professor Donnelly actions on 31 March 2021 before Dan was released were wholly inadequate. I find that Professor Donnelly knew there was an application from the NR from a mental health act assessment and why and that it should have been obvious to him that even in the absence of a formal request from the AMPH service that Dan needed an urgent mental health assessment in custody and prior to release. Professor Donnelly knew that there was a person in custody with a chronic psychotic disorder who was likely to be suffering schizophrenia who was off medication and who had now potentially committed a serious assault which was completely out of character. Alarm bells should have been ringing for Professor Donnelly. Professor Donnelly may have been busy in clinic but that did not prevent him giving robust information and advice to the AMPH service and making clear that an MHA was required as a matter of urgency. I consider it was not appropriate to simply rely on an assessment by a custody nurse who did not know Dan and who had no access to collateral information. A custody nurse assessment is not a substitute for an assessment by a consultant psychiatrist and second doctor. Also, there were reasonable grounds for the NR request - which was the threshold that Professor Donnelly had set out in the professionals meeting on 22 February 2021 - namely out of character altercation with the landlord. I also note that Professor Donnelly was concerned for his own safety on 1 April 2021 but did not appear to give any thought to the risk Dan may pose to members of the public were he to be released on 31 March 2021 without a full mental health assessment. I find this to be extremely reckless conduct on the part of Professor Donnelly and Alison Cole both of whom would have known that a custody nurse was in not position to carry out a robust risk assessment in police custody in the absence of full medical records and collateral history. This was a significant missed opportunity as in Professor Shaws words it was a good moment to

assess Dan as he just been violent, and it was shortly after the index offence. I also note that the view of the CPS was not made until 7 October 2021 and so is not a relevant factor at this stage in decision making but in any event it records that the landlord had alleged that Dan was paranoid and suffering with mental health but that the CPS also took into account Professor Donnelly's assessment of Dan on 12 March 2021 which suggested that Dan was not unwell which as I have already indicated was a flawed assessment.

At some point on 1 April 2021 Alison Cole spoke to the vicar who expressed concerns regarding Dan's welfare saying he had deteriorated, is looking gaunt and was paranoid. This information should have been obtained before Dan was released from custody as it also evidenced the need for an urgent mental health act assessment.

Immediately after Dan's release from custody in early April 2021 Nicola Mort a manager in the AMPH service took over conduct of the case as the AMPH service and the staff were feeling under pressure and appreciated they were now facing very serious criticisms from the Harrisons about Dan's assessments by the service (i.e., the Will Johnson assessment and failure to undertaken a MHA in when Dan was in police custody). At this stage matters had escalated as the Harrison's had directly made contact in 1 April 2021 with the Interim Chief Executive Richard Evans who was pursing the matter and asking questions of Stephen Jones and Richard Maggs. I consider that thought should have been given by the AMPH service as to whether this appropriate for Nicola Mort to take the lead as she was not sufficiently independent from what had gone before. In particular, she had signed off Will Johnson's assessment on 9 February 2021, which was being challenged by the Harrisons. I consider that it would have been more appropriate for someone else within the AMPH service unconnected to events to have the lead at this point and for there to have been a clear attempt to openly review the AMPHs service involvement to date with a fresh perspective. I also find that despite not having received a formal complaint the AMPH service should have initiated a complaints process to ensure a degree of transparency, oversight, and review of what had happened. This did not happen. I consider that part of the reason for this was that a defensive mindset had now emerged within the AMPH service given scrutiny was being brought to bear by very senior members of the health board. This was very clear from the way in which Nicola Mort gave her evidence. It was clear that Nicola Mort did not see it as her role to critically examine what had gone before but rather to defend her service and her staff. I also note that Nicola Mort worked alongside Martin Reeve and from mid- April 2021 he was expressing a very defensive mindset in e-mails raising his belief that he thought the Harrisons were not behaving appropriately in criticising professionals. Similar sentiments were expressed later on by Ross Wheelan who also worked under Martin Reeve in Ty Einon where he stated in an e-mail that the Dan was a difficult case that the Harrisons had in effect used their position to keep Dan under services for longer than required. I am satisfied that these

inappropriately defensive sentiments were probably held more widely and were being expressed in Ty Einon at this time and that it is likely that Professor Donnelly would have been aware of these views.

There was a professionals meeting on 20 April 2021 including senior members of SUBHB, including Nicola Mort, Professor Donnelly, and Richard Maggs, where Dan was discussed. This meeting was not minuted when it should have been. Particularly given it should have been obvious to SUBHB and the AMPH service that by this stage that they had in effect received a number of complaints about the service and were likely to receive a formal complaint.

A plan was set down to conduct a formal MHA in custody when Dan returned to answer bail with an alternative of referral for an appointment with CMHT for assessment for secondary care (should Dan not be detainable). This was because Professor Donnelly and Nicola Mort both confirmed that it had been accepted by this stage that Dan's mental health had deteriorated and that this had been recognised in the meeting and that it was understood that Dan needed a further assessment and referral to the CMHT for assessment for access to secondary MH. This was a reasonable plan in terms of the immediate tasks to ensure Dan was assessed. However, Richard Maggs described it in an email to the family as "*a robust plan to address Dan's needs and risks when he returns to Swansea and a contingency plan should he fail to attend for his bail hearing*". I find the following: first, the plan was not documented when it should have been. A plan cannot be robust if it is not documented; second, there plan was not robust because as accepted in evidence to me by Professor Donnelly it failed to contain a contingency plan clearly documented on Dan's medical records setting out what should happen if he was not detainable under the MHA and refused to engage. I find this was a significant failure because when the Harrison family were seeking to get help for Dan from December 2021 to March 2022 they were told by multiple mental health professionals looking at Dan's notes on the PARIS system that he was not open to services and there continued to be a reference to Dan simply being in conflict with his parents over a lifestyle choice and that this should be referred to the GP or the police. I also find that in this meeting there was no discussion or critical thinking as to the state of the collateral information on Dan and whether further information needed to be obtained in advance on any further assessment under the MHA 83. Nicola Mort accepted that no further information was gathered in April 2021and before the MHA on 27th April 2021. The GP was not contacted, the Vicar was not contacted, there was no further contact with Dan's brothers or any of Dan's friends, there was no contact to Gayle Kavanagh, there was no consideration of whether the landlord could be contacted or search for collateral information in the records about the landlord (which was in the records). I accept that Dan's parents were regularly feeding in information to SUBHB during April 2021 and that they had already provided significant collateral information. But I find that more could and should have been done by the AMPH service to ensure they had a full holistic understanding of Dan given the seriousness and to ensure that they complied with their and the local authority's duty under s.13(4)

MHA 83. The fact that this was not done is evidence of a fixed mindset by Nicola Mort who did not consider that anything more was required.

Finally, I find that the only reason this professional meeting and a plan was put in place was because the AMPH service and professionals involved with Dan were facing pressure to act. In other words, professional failed to think about and appreciate Dan's deterioration and to consider the risk he may pose in a timely manner and to put a plan in place and only did so when forced to do so after the Harrisons involved the Interim Chief Executive was now involved asking sensible questions and demanding answers. Not all families have connections in SUBHB, I find that the clinicians and professionals involved in Dan should have acted much sooner and of their own volition and it should not have taken an intervention of the sort that I have indicated.

Dan was then assessed in police custody under the MHA 1983 on 27 April 2021 by Professor Donnelly, Nicola Mort and a second consultant psychiatrist who did not know Dan. The outcome was that all were agreed that Dan did not meet the threshold for detention under the MHA 1983 as there was no evidence of psychotic material and no evidence of a mental disorder warranting detention in hospital. I consider that there were clear flaws in the assessment and that there were warning signs in the assessment that Dan was mentally unwell that were not appreciated in a context where Dan possibly posed a risk to himself and others. By this stage Dan was known to be suffering from schizophrenia and the collateral information suggested that he had relapsed and was possibly representing as a risk to self through self-neglect and was possibly a risk to members of the public. There was evidence available to clinicians that family were concerned Dan may be at risk of stabbing someone and that Dan had seriously injured his landlord's finger by biting it such that surgery was required. Despite this prior to the assessment there was no review of the colleterial information to ascertain what more was required. No one obtained independent evidence from the police of the circumstances surrounding the incident with the landlord and no-one considered whether it might be appropriate to speak the landlord or to check the collateral history on file which included information from Gayle Kavanagh setting out the landlords concerns about Dan's behaviour which suggested Dan was becoming aggressive and that the landlord was wary of Dan, all of which was totally out of character. By this stage Professor Donnelly had access to some information from the family clearly indicating that Dan was very adept at hiding his delusional beliefs. He told me that the assessing team were concerned to understand whether Dan was masking symptoms, but I not satisfied that the assessing team did in fact adequately focus on the collateral information from the family and I am not satisfied that the full extent of what was known to services was robustly considered prior to the assessment and then properly explored with Dan. This is because there is no evidence in the notes of the assessment that any of Dans' paranoid delusions and psychotic beliefs as had been reported by the family were explored with Dan in the assessment. I have heard that this was the only way to assess

whether someone is masking symptoms. It was suggested to me in evidence by Professor Donnelly that despite not being documented Professor Donnelly has a memory of Dan being asked about his thoughts on Covid and about technology. This is not the same as asking a person directly about a specific delusional belief. In any event Professor Donnelly told me that Dan stated that his parents worked for the NHS and '*were involved with it all*' but wouldn't go any further. This was an obvious red flag indicating possible masking of psychosis, but it was ignored. When Dan was asked about technology, he stated that when you use your phone apps take your information. Professor Donnelly in giving evidence in court didn't see anything unusual in Dans answer on apps because in answer to my questions he stated agreed with Dan stating, "you know if you use an app somebody will take your information, that's part of the process". I find that once again Professor Donnelly was too willing to accept that Dan's answer here was a reasonable answer as opposed to evidence of a paranoid delusion on Dan's part that fitted with the collateral information. There is also evidence of a lack of critical thinking about what Dan was saying, for example, Dan was stating that Olanzapine never helped him which evidenced a lack of insight into his condition which starkly contradicted the historical medical notes. There is also apparently no probing of Dan's assertion that his parents are toxic and critical thinking about whether this contradicted what was in the medical notes. Nicola Mort's mental health act assessment documentation also indicates the extent to which over reliance was placed on Dan's assurances that he felt well and nothing like he did in 2007 and how Dan's version of events over the incident with the landlord were accepted without question. Dr Owen was of course dependent on what she told by Nicola Mort and Professor Donnelly as she did not know Dan. I consider Professor Donnelly and Nicola Mort did not have a proper understanding of the collateral history. I consider it highly likely both Nicola Mort and Professor Donnelly attended this assessment with a fixed mindset and one which sought to defend their involvement to date. I also consider that all these flaws likely impacted on the briefing given to Dr Owen which was likely to have included reinforcing the validity of the Will Johnson and Dr Heke assessment and Professor Donnelly's previous assessment (all of which also did not explore the psychotic material with Dan and all of which were seriously flawed).

Professor Shaw tells me that whether Dan should have been detained at this stage is a tricky one, all the evidence is stacking up, it's certainly on the edge and there is definitely evidence of deterioration of health, and it is very much in the balance. She felt that Dan needed further assessment. Dr Haynes (who is not an independent expert in this inquest, but an expert instructed by SUBHB for another purpose) considers that the calm presentation and lack of psychotic symptoms at interview suggests that a reasonable body of clinicians would not have detained Dan under the MHA 83. I do not agree. Having heard the evidence of Professor Donnelly and reviewed all the records I consider the assessment that was conducted was fatally flawed for all the reasons I have set. I also find that the assessing team were also deprived of all the understanding of Dan that would have been obtained had he received assertive outreach from June 2020 to when he left Swansea on 1 April 2021. I find that

had an adequate assessment been carried out with adequate weight given to all available collateral information and with a full understanding of Dan as obtained from extensive assertive outreach then there was a possibility that a decision would have been reached that Dan ought to be admitted to hospital for further assessment pursuant to s.2 of the MHA 83 on 27 April 2021. I therefore find that these failures in the mental health act assessment process on 27 April 2021 combined with the lack of assertive outreach to Dan from June 2020 possibly contributed to Kim's death.

Following the assessment there is no evidence that Dan was offered an assessment by the CMHT (as had been agreed) but in any event even if he had I consider that he would have rejected the offer as he had a clear plan to leave the Swansea area and move to Falmouth which we know he then did. Professor Shaw said that the follow up assessment should have been conducted whilst Dan was in custody as he was there, and it was known that Dan didn't respond well to appointments but that whether Dan would consent to care co-ordination was unclear – I agree.

Nicola Mort did then appropriately contact and pass on information to the CMHT in Falmouth but when this was done it indicated that Dan may relapse over time and come to their attention (not that he had in fact relapsed) and gave the phone number of the crisis team and the CMHT in Swansea to Falmouth stating that they were to contact these team if he came to the attention of Falmouth CMHT. I accept that more information could have been given but, in the event, Dan didn't contact services. Nicola Mort gave out these phone numbers but then did not ensure there was a documented plan in Swansea that could be actioned if Falmouth in fact called the crisis team and CMHT in Swansea. I find that Nicola Mort did not check to ensure Dan's PARIS records were accurate and up to date after 27 April 2021 or at any date thereafter and she have done so. This was a significant failure because it meant that the flawed and out of date Will Johnson assessment of 9 February 2021 remained front and centre of the PARIS records with apparently no mention of more recent events and the escalation of risk and emergence of violent behaviour by Dan. PARIS clearly should have been updated to include an up to date history section, a risk assessment, a risk management plan and a care plan in the event that Dan or his family made contact with services. This should have been discussed with and agreed with Dan's parents subject to confidentiality being maintained. This could and should have actioned by Professor Donnelly and Nicola Mort and indeed any senior member of the health board actively engaged with the Harrisons could have queried whether this had happened (for example Richard Maggs). I find they nobody did this and that this significant failure.

Dan returned briefly in August 2021 and went to Ty Einon and reported intrusive thoughts but did not request help. The fact that there was no documented plan in Ty Einon meant that no action was taken by staff in response to Dan's attendance. Again, this was a result of Professor Donnelly and Nicola Mort's failure to put in place a risk and care management plan.

In December 2021 to Early March 2022 Dan returned to live at his parents' house and I accept the evidence that I have heard from Dan's family, namely that he was clearly very mentally unwell, and that the Harrisons were in a very difficult position living with Dan. On his return to Swansea Dan's family described that Dan was clearly psychotic and behaving in an aggressive and controlling way, particularly in respect of his parents in respect of whom he held delusional beliefs. The Harrison's needed help with Dan and urgently. On 19 December 2021 Dan's parents contacted mental health services as the NR requesting a MHA assessment which resulted in discussions in the Assessment and home treatment team within mental health services and the emergency duty team and the AMPH service. The decision taken by two members of the AMPH service was that there was no new information of risk to self or others beyond that last documented information which was the Will Johnson assessment that Dan was wanting to live an alternative lifestyle and reference to a psychotic episode in 2008 induced via drugs via the rave culture and that the crisis team should respond that follow up should be via the GP. Once again this was clearly not in compliance with the s.13(4) of the MHA 1983 as not collateral information was sought or afforded weight.

The same view can be found expressed by other mental health professionals accessing the medical records in February and March 2022, including from one working for another health board inside South Wales Police. I therefore find that there was a serious failure by the local authority AMPH service (including Nicola Mort) and Senior Members of SBUHB (including Professor Donnelly) to ensure that Dan's current risks and the concerns being expressed by the Harrisons were fully recorded on Dan's medical records with a clear plan of action set down should help be requested in relation to Dan. The plan should have clearly set out that if services were contacted requesting an urgent assessment under the MHA 83, then one ought to be carried out.

On 27 January 2022 Dan was assessed by Professor Donnelly. This was an assessment that was offered and took place remotely over a computer. When I questioned Professor Donnelly about this he reluctantly accepted that this was inappropriate and explained that in certain cases he would see people in person. I find that Professor Donnelly's decision to see Dan remotely clearly illustrates the extent to which Professor Donnelly even by this stage had simply failed to properly focus on and consider the import of what had been communicated to him about Dan and his psychosis. The assessment on 27 January 2022 found that Dan was stable, insightful, and reflective. I am satisfied that at this stage Dan was serious mentally unwell and psychotic and this conclusion is a stark illustration of once again the extent to which Professor Donnelly continued to take Dan at face value with no weight being attached to collateral information (which did not indicate Dan was stable), no exploration of Dan's specific delusional beliefs and no consideration of the possibility of Dan masking, even though I find there was some emerging evidence of psychosis at this assessment.

Professor Donnelly also made no attempt to contact the Harrisons to obtain more up to date collateral information which was permissible under the MHCOP provided confidentiality was maintained for Dan. I also heard from Professor Shaw this was good practice and I find the Harrison's should have been contacted at this stage. If this had happened Professor Donnelly would have been in a much better position to assess Dan appropriately.

By 27 February 2022 the Harrisons were reporting to SWP that they could not approach Dan because he would become violent, and that the crisis team had simply advised to call the police and that Dan was hallucinating. SWP attended on 27 February 2022 and 1 March 2022 but Dan was able to switch and sound plausible as soon as the officers arrived with officers being given false reassurance. On 27 February 2022 even though Dan was plausible officers could see Dan was unwell and they were stating to a mental health professional, '*I'm worried when he does snap, he snaps"*. I have heard Dan speaking on the phone with then mental health professional who was from another health board working for SWP and after she consulted the PARIS system which had not been updated, she advised that it sounded like Dan's parents could be overbearing and that Dan just needed a bit of space. This mental health professional was working from inadequate records and acted appropriately. Again, had the system been updated with an appropriate risk assessment and care plan in place I find that this contact would have led to Dan being seen for an urgent assessment under the MHA 83. Whilst this was only 2 days before he was taken to Cefn Coed, I do consider an assessment under the MHA 83 at this stage would have likely resulted in Dan getting access to Ward F sooner than he did.

I consider that by this stage it was inappropriate for SWP to be left to deal with Dan and for the Harrison's to be left with option but to rely on SWP. This was not a police matter and vital police resources when used when the SUBHB and AMPH service should have been treating/ assessing Dan.

O 2 March 2022 Dan was taken by SWP officers to Cefn Coed after they attended at the Harrisons' home. Dan was very clearly behaving in a psychotic manner. SWP officers were shown a number of videos of Dan behaving in an aggressive and threatening manner to his parents. Officers downloaded these videos and showed them to staff in Cefn Coed hospital and noted on the police record I quote '*It is only a matter of time before he seriously hurts one of his family members*'. On being show the videos Cefn Coed staff agreed that the videos were concerning and that he appeared to pose a risk to his parents and that Dan needed to be admitted to Ward F in Neath and Port Talbot Hospital which he agreed. At the time and indeed now Ward F is the single point of access for Swansea Neath and Port Talbot. It was the only place were those in crisis could and can be admitted formally and under detention powers under the MHA 83. It is a 21 bedded unit. This was a policy introduced during the pandemic to manage the risk of the spread of the virus, but I understand this was under consideration

before. Prior to this three units received people in crisis admitted under the MHA 83 from the Swansea wide area.

The videos of Dan were not shared with staff by at Cefn Coed to Ward F, but they were documented, the videos and audio were mailed by the Harrisons to a ward manager at Ward F but he could not open them due to the system in use and so nothing more was done. This was inadequate. The videos were relevant to the risk assessment and the Harrison's should have been told to attend in person with the videos so they could be viewed.

I find that it was appropriate to admit Dan to Ward F. On admission Dan disclosed smoking marijuana 2 weeks prior. Dan was seen on admission by a consultant psychiatrist who also saw a letter from the Harrison's setting out their concern. Dan was clearly mentally unwell and expressing paranoid beliefs about his parents accusing them of sexually harassing him in his recent past and given he was asking to leave the ward continuously and had no insight he was detained under the MHA 83. There is also reference to him thinking Kim was not his dad and his parents needing to be sectioned and so there was a request that he was placed on a section 5(2) MHA 83 emergency holding power as it was assessed that he was a potential risk of violence to others. This then had to be changed so that the correct forms were competed under s.2 MHA 83. I find that this was a simple mistake on the paperwork.

Dan was first seen on the ward by the consultant psychiatrist Dr Kerine Robertson for Ward F on 4 March to compete the s.2 paperwork. No plan was put in place for Dan as I was told there was evidence of suspected drug usage so the practice would be to wait and see before prescribing medication. No thought was given to whether another treating team needed to be consulted. The medical notes were not consulted. Dan was only seen for a full assessment by Dr Robertson on 8 March 2022. I find that Dan should have been seen and reviewed by an MDT within 24 hours of admission with a clear treatment plan put in place, including the prescribing of olanzapine and a plan for what was to happen if Dan refused medication. I heard from Professor Shaw that this did not need to wait for as long as Dr Robertson suggested as there was no evidence of drug intoxication or withdrawal. I further find that Dan's risk assessment was superficial and there was not enough interrogation about risks issues, including what his ideas about his parents meant to him and whether he thought about acting on them. There was no risks assessment to deal with the risk of absconding. These were all serious failures in Dan's care. This was in part contributed to by inadequate training off staff in Ward F on risk assessments. I also accept the evidence of Dr Robertson and the ward managers that the levels of acuity in Ward F and indeed the pressure on staff in Ward F had increased significantly since it became a SPOA. I heard that this has created pressures as there is more

paperwork to be prepared for Tribunal and a higher turnover of more unwell patients. I consider that this also likely impacted on Dan's care whilst in Ward F.

Professor Shaw told me that Dan's risk to his parents was high as he held delusional ideas about them that were making him agitated, he had acted on that aggression in a verbal manner, and he had passivity where he had ideas that his parents had interfered with his body, and this was distressing him. I am not satisfied that Dan was properly questioned and assessed by Dr Robertson on this issue of risk to others and I find that it is telling that in the section 2 paperwork that she completed and there no mention of risk to others. I find it likely that this was missed by Dr Robertson despite the apparent concern around passivity (which is not documented). I find that there was a high risk of aggression from Dan towards his parents but also that in the absence any proper interrogation of Dan's thoughts and whether he would act on them, staff on Ward F ought to have worked on the basis that Dan presented a high risk of serious violence to his parents were he to return to the family home and this should have been reflected in a documented risk assessment. Staff clearly did understand that Dan presented a risk to his parents from the delusional beliefs as they said as much to SWP when Dan absconded, stating "*we've got concerns he may want to hurt them*". This goes beyond concerns around verbal aggression.

In terms of the risk of absconding Professor Shaw told me that had this been assessed it would have been low. I do not accept that Dan's level of risk alone ought to have led to a different relational security plan over and above the general plan, even where the risk of absconding was low. The evidence was that given the low risk of absconding Dan did not require any more enhanced observations. So in essence the relational security plan for Dan was the same as it was for everyone else. I do not consider that Dan should have had his money removed from his possession but the amount in his possession should have been known to staff and documented.

There was some limited training for staff on what to do in proximity to the door and to be aware of tailgating, but the training was clearly inadequate at the time that Dan was able to abscond. Dan was able to push past a member of staff who was talking through the door to another patients' parents, which would not have happened if staff had been given robust training.

Ward F was meant to operate an Open Door Policy, but I am told that this was not possible or safe because some patients in Ward F posed a risk to either themselves or others. I understand SBUHB recognise that because "*Ward F is an acute assessment ward it can have high risk inpatients and hence the ward needs to be fit for purpose for the differing levels of security that are needed for the*

differing types of inpatients".[1] Consequently, the entrance to Ward F was supposed to be kept locked with informal service users being let on and off the ward under supervision. I therefore find that SBUHB knew in advance of the Dan' death that they were operating a system that was supposed to protect the lives of members of the public who may be at risk from detained patients. I also find that despite this here was no evidence that training, or information had been provided to staff as to how to manage ward safety in these circumstances and there had been no review of Ward F, and its security needs to be completed to assess for any areas of concern or weaknesses.

I therefore find that the security systems in place at the time in relation to Ward F were not fit for purpose and were not capable of being operated in a way that would protect life, to the greatest extent reasonably practicable. 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 training and policy (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 because SBUHB had not conducted a review of the security of Ward F despite a significant increase in the rate of absconding.

I find that this system failure contributed to Kim's death.

I find that it was appropriate not to forcibly medicate Dan with Olanzapine prior to him absconding but that there should have been a documented plan on what to do it Dan refused his medication. It is impossible to say whether if this had happened Dan would have voluntarily taken his medication.

After Dan absconded, I find that the staff in Ward F appropriately contacted and updated SWP of their concerns. The only piece of information that could not be provided to SWP related to what Dan had in possession including money as this had not been adequately document by staff in Ward F. I find that no-one could have foreseen that Dan would have been able to catch a taxi and return to the family home in the way that he did and as quickly as he did. I therefore find it was reasonable for SWP to deploy the initial resources to search in the vicinity of Ward F and not the Harrison's family home. SWP were not in possession of evidence to suggest that Dan presented a real-immediate risk to Kim's life.

Finally in relation to the Haynes review. I find that the then Interim Chief Executive Richard Evans was concerned to assist the Harrisons as he knew them. This also placed him in a very difficult position because the formal complaints process was bypassed. This Haynes review was commissioned in response to the Harrisons formal complaint of June 2021 which they were encouraged to make by

[1] Patient Safety Incident Investigation INC - 175329

Richard Evans. Dr Haynes was asked to consider all aspects of the care and treatment of Dan, but he focused on the Will Johnson assessment under the MHA 83 and events leading up to 27 April 2021. I was told by Richard Evans that the purpose behind instructing Dr Haynes was to provide some reassurance to the Harrisons (to the extent that the report could be shared which may be limited) and to learn lessons. I accept that this may have been the intention at one stage but there came a point when the report was received by Richard Evans in November 2021, and it would have been immediately obvious to him that the report was critical of employees of the service for which he was responsible (Professor Donnelly). It then took 10 weeks for the report to be shared by Richard Evans with Stephen Jones for further information to be sought so that the report could be finalised. After Stephen Jones was tasked, the report was finalised in just over 4 weeks. At no stage was Professor Donnelly told that he was subject to criticism in the report by Richard Evans. Richard Evans accepted to me in evidence that he should have shared the information with Professor Donnelly. I find that I did not receive a satisfactory explanation as to why it took 10 weeks for the report to be shared by Richard Evans with Stephen Jones or why it was never shared with Professor Donnelly. I find that the Haynes report should have been finalised as a matter of urgency when it was received and at the very least shared with Professor Donnelly well before his final assessment of Dan in January 2022. This was a significant missed opportunity for SUBHB to reflect on some independent scrutiny that had been brought to bear on their care and treatment of Dan before Kim's death.

16 April 2024

Kirsten Heaven
Assistant Coroner for Swansea Neath and Port Talbot