Hampshire County Council & Portsmouth City Council

Response to the PFD (Prevent Future Deaths) Coroners report touching the death of Richard Walsh

Date of Death: 19/07/2015
Case Number:-01936-2015

1.0 Introduction

1.1 This response is being provided on behalf of Hampshire County Council (HCC) as the responsible Local Authority which employed [redacted] the Approved Mental Health Professional (AMHP) involved in the Mental Health Act assessment of Mr Richard Walsh conducted on the 27th June 2016.

This response is also being supported by Portsmouth City Council (PCC) as the current employer of [redacted] in his role as AMHP and as a key agency involved in the local health and social care system in Hampshire.

1.2 HCC and PCC share an equal commitment to address the serious concerns raised by the Coroner and the findings of the Inquest Jury in relation to the tragic death of Mr Richard Walsh. Having reviewed the PFD report, HCC and PCC have considered the role of the local authority in the circumstances of their statutory responsibilities for providing an AMHP to carry out an assessment under s13 Mental Health Act 1983 with specific reference to persons in Police Custody.

1.3 This response is structured in light of the review of the PFD report which references specific concerns regarding AMHP practice, Information Management, the standard of MHA assessments (in Police Custody), training and development of AMHPs, professional registration of [redacted] and the wider systemic learning both locally and nationally, stemming from this incident.

2.0 AMHP Professional Practice

2.1 *Communication with Relatives & 'Nearest Relatives' as defined under s26 Mental Health Act 1983*

In light of evidence made available at the Inquest, a matter of concern has been raised in the PFD report regarding communication between those conducting the assessment and the patient's relatives.

The Mental Health Act (s26) is prescriptive about the identification and statutory role of the Nearest Relative of the patient as a means of providing a safeguard within the Mental Health Act assessment process. The AMHP role in turn, is governed by a set of duties under Statute to ensure that the Nearest Relative is properly consulted and included in the process as required. Duties toward the role of 'relatives' is informed by s13(1A) (b) requiring the AMHP have regard 'to any wishes expressed by relatives

of the patient'. Best practice is also informed by principles of the Mental Health Act Code of Practice for the AMHP role.

Due to the findings of the Inquest concerning the assessment conducted with Mr Walsh, HCC/ PCC will be developing AMHP practice guidance to support decision making for when a relative needs to be consulted about someone presenting in the Police Custody environment. Such AMHP guidance will highlight the necessity for such consultation on the grounds of the gravity of the presenting facts, the nature of the offence, the history of the individual, the availability and suitability of the relative, the views of the person subject to assessment and other relevant criteria.

2.2 *Examination of the Custody Log and/or police station records*

The Coroner has highlighted the fact that the MHA assessors did not directly examine the custody record or log.

HCC/ PCC fully support the requirement that AMHPs need to directly scrutinise the Police Custody record and not rely solely on verbal feedback from Police staff.

HCC/ PCC will be publishing guidance to AMHP staff referencing this requirement.

2.3 *Consultation and consideration of the 'patient' medical forms*

The Coroner has highlighted the fact that the MHA assessors did not directly examine the 'Detained Persons Medical Forms'.

HCC/ PCC fully support the requirement that AMHPs need to directly scrutinise the 'Detained Persons Medical Forms' and not rely solely on verbal feedback from Police staff.

HCC/ PCC will be publishing guidance to AMHP staff referencing this practice requirement.

2.4 *Accessing information from Police Custody Officers*

The Coroner has highlighted that the Custody Officers and the MHA assessors never spoke.

HCC/ PCC concur that the AMHP needs to speak directly with the Police Custody Officer as a priority when carrying out each assessment in a Police Custody Centre.

HCC/ PCC will publish guidance to AMHP staff referencing this requirement following further liaison with Hampshire Constabulary.

3.0 Management of information related to the MHA assessment process

3.1 *Sharing AMHP reports with Prison healthcare and/ or GP practice*

The Coroner report has highlighted the need for a national process for information sharing in view of the role, in this case, of general practice and/ or prison healthcare.

Local services across Hampshire record information about people using services on a variety of different systems regulated by Information Governance policies. HCC/ PCC would concur that the sharing of such sensitive information will be necessary in the specific ongoing provision of care and support of vulnerable persons involved in the criminal justice system.

HCC/ PCC will provide a clear set of practice guidance to ensure that AMHPs are able to provide relevant information 'in confidence' to GP practice/ prison healthcare regarding people who have been subject to MHA assessment in Police Custody.

3.2 *Sharing AMHP reports with Police*

The Coroner report raised concern where there was no report or letter or appropriate communication about the MHA assessment completed in the Police Station to subsequent health care providers. The Coroner further stated concern in regard to the availability of relevant information for the purposes of the Prisoner Escort Record (PER).

HCC/ PCC will be working with local NHS Provider Trusts and Hampshire Constabulary to review information sharing with the Police following joint assessment in Police Custody.

In November 2016 HCC/ PCC have introduced a requirement for AMHPs to receive a written medical report from the assessing Doctors in circumstances where their assessment has <u>not</u> led to the provision of medical recommendations supporting application for detention under Part 2 Mental Health Act 1983. The completion of this report will evidence the rationale for clinical decision making and corresponding AMHP decision making (see Appendix One).

4.0 Maintaining and improving standards of MHA assessments by practitioners in Police Custody

The standard of mental health act assessments is brought into question by the Coroner in light of the findings from this inquest. Certainly the conduct of each of the practitioners involved in this case is referred to separately.

HCC/ PCC recognise that a robust governance framework is required to provide greater assurance and transparency to the public whereby decisions are taken by AMHPs when assessing persons under the Mental Health Act whilst in Police Custody. Such a framework will include the monitoring of MHA outcomes for persons arrested for an offence in need of a MHA assessment, information sharing –

both to inform decision making and outcomes for the benefit of other agencies, communication with relatives/ carers, AMHP training records specific to assessments for people arrested for an offence.

5.0 Training and Professional Development for AMHP staff when dealing with assessments in Police Custody

The Coroner has raised concern about the availability and provision of AMHP training on MHA assessments in police stations.

In light of the findings of this inquest, HCC/ PCC will be reviewing the current professional development opportunities for AMHP staff in order to ensure the standard of practice when assessing persons in Police Custody is consistent and in line with best practice.

The findings of this report will also be shared with AMHP training providers, the Health and Social Care Professionals Council (HCPC) and other relevant professional training bodies to ensure that AMHP training and refresher training includes the learning from this report.

6.0 Professional Regulatory review of [redacted]

Following the tragic circumstances of this event, [redacted] *and Portsmouth City Council as his employer, can confirm that his professional practice as a registered social worker was referred to the Health and Care Professionals Council (HCPC) on the 03/10/2016.*

HCPC requested information connected to the case and Portsmouth City Council has provided them with the following documents:

1. The Jury's Narrative Verdict
2. The Coroner's Report
3. The Prisons and Probation Ombudsman's report into the death of RW
4. The independent social work report commissioned by Hampshire County Council written by [redacted] and dated the 16th of September.
5. A report from a senior manager at Portsmouth City Council regarding [redacted] current practice.

HCPC have reviewed these documents and have decided that they will not be holding a fitness to practice hearing. They will be taking no further action and the case will be closed.

In addition to the above, [redacted] was randomly selected by HCPC, as part of the re-registration process to provide evidence of his continuous professional development. [redacted] has provided a portfolio of evidence and this resulted in his re-registration being confirmed.

PCC have audited [redacted] assessments to ensure they are of a good standard. This practice is undertaken routinely within the Portsmouth AMHP service and will continue for all AMHPs. The manager of the service has been satisfied that [redacted] work is of a high standard.

7.0 Systemic learning

The PFD report highlights the range of organisations involved in the experience of Mr Walsh and his family through the course of his dealings with the criminal justice system.

HCC/ PCC will be seeking to work alongside the relevant agencies in respect to their key responsibilities under the Mental Health Act 1983, specifically in relation to their duties to make arrangements for providing an AMHP to consider a 'patients' case.

HCC/ PCC will be seeking to share the learning from this case with relevant agencies to improve practice of the AMHP when assessing persons in police custody.

8.0 Summary

The inquest into the death of Mr Richard Walsh has highlighted the very sad circumstances which led to his death by suicide on 19th July 2015. The Coroner has raised a number of concerns about the role of the AMHP and both psychiatrists in this case citing Neglect on four counts.

HCC and PCC are committed to learn from this tragic experience in light of the findings of the Coroner.

[redacted]

Head of Mental Health and Substance Misuse

Signature:-