GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ein cyf/Our ref: [redacted]
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Dyddiad/Date: 08 April 2015

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Mr Gareth Glyn Lewis
Area Coroner – Carmarthenshire and Pembrokeshire
Coroner's Office
Town Hall
Hamilton Terrace
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SA73 3JW

Dear Mr Lewis

Re: Regulation 28 Report to Prevent Future Deaths

Thank you for the Regulation 28 Report that I received from you following the Inquest into the death of Laura Hill.

Your report identified a number of matters of concern and I shall address them each in turn.

1. **That there appears to be a breakdown in the transition and passing of information between the Child and Adolescent and Adult Mental Health Teams.**

In January 2013, the Health Board provided transition guidelines in relation to Specialist Child and Adolescent Mental Health Services to Adult Mental Health and Learning Disability Services. The document was circulated across all the relevant teams and provides clear transition guidelines in line with best practice and government guidelines with regards to transitions between services. It is recognised that times of transition can pose potential risks if they are not robustly managed and the guidance enhances the safety of the transition process with clear steps for professionals to follow.

2. **Staffing levels on the ward need to be reviewed as it was felt that staffing resources were stretched at the relevant time (1 nurse and 3 support workers on a 16 bed Acute Ward).**

Since the incident occurred, the ward has reviewed (May 2013) the shift pattern and now works on the basis of four staff as a minimum per shift, with an additional staff member on a flexible shift to cover the busier part of the day. This cover relates to nursing staff only. Additionally, the ward would have the manager and other disciplines providing input. Staffing levels have to be flexible and dependant upon patient activity and complexity. This requires increasing staffing levels at short notice, particularly where one to one observations are required. There are systems in place on a twenty four hour basis to sanction increased staffing levels when they are required.

The ward has also reduced to fifteen beds since the incident.

3. **There was a training need identified in relation to the Section 136 procedure when patients are handed over by the Police.**

A multi-agency Section 136 Protocol was signed off in November 2014. This Protocol details partner responsibilities in relation to Section 136. There are clear guidelines to be followed and these include points of transition with associated documentation. Nursing staff on St Caradog Ward receive training in respect of their responsibilities as part of their induction. Further follow up training is thereafter provided directly to staff on the ward. Medical staff also receive training on induction as well as on-going through the Post Graduate Medical Training Forum. Medical staff have protected training on a weekly basis.

4. **There was a training need identified in relation to what constitutes 'absconding' and what should be done by staff following an incident of absconding.**

Guidance in relation to the management of those patients who abscond from the in-patient ward has been provided to all relevant staff by the Head of Acute Care Services.

5. **The Door Policy on the ward needs to be reviewed as a patient was able to abscond without staff noticing.**

St Caradog is an open adult admission ward. It is not a secure or locked ward. The ward has the option to lock its door, although this has to be done in line with guidance, as provided by the 1983 Mental Health Act – Code of Practice. An up to date policy is in place to guide staff in relation to the locking of doors on such units as well as the recording of these instances.

All patients are risk assessed and assigned observation levels in line with the outcome of the risk assessment. Both risk and observation levels are subject to continuous review.

6. **There was a training need identified in relation to Personality Disorders.**

Since the incident, there has been an enhancement of training in relation to personality disorder that has taken place within the Mental Health and Learning Disabilities Directorate. These include: Dialectical Behavioural Therapy, Emotional Coping Skills and Knowledge and Understanding Framework for Personality Disorders. The Health Board is committed to developing the use and range of psychological intervention and, in line with Welsh Government guidance, has a Committee dedicated to enhancing the delivery of psychological therapies across the whole service.

Additionally, St Caradog, as well as other adult mental health wards, has dedicated psychology input both to provide patient assessment and intervention as well as supporting ward based staff with guidance in relation to clinical care planning and optimum approaches to patient care.

7. **There was a training need identified in relation to powers of detention and when those powers can and should be used.**

Registered clinical practitioners are aware of the powers of detention which are available to them. On-going Mental Health Act and Mental Capacity Act training (as detailed previously) ensure that clinicians are updated in relation to the application of powers of detention.
I trust that the above response satisfactorily addresses the matters of concern that you have raised. If there are any further queries, please do not hesitate to contact me.

Yours sincerely

[redacted]

Steve Moore
Chief Executive