GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Ysbyty Gwynedd, Penrhosgarnedd, Bangor,
Gwynedd, LL57 2PW

PRIVATE & CONFIDENTIAL

Mr John Gittins
H.M. Coroner North Wales
(East and Central)
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Dyddiad / Date: 12 July 2018

Dear Mr Gittins

Re: Regulation 28 relating to Mr Neville Welton

Further to the recent Regulation 28 issued by yourself in relation to the death of Mr Neville Welton. Please find below the Health Board response to your concerns which I trust will provide you with assurance about how we intend to strengthen our processes to avoid a reoccurrence of the issues you have identified.

The concerns you raised were:
"I am concerned firstly by the length of time taken by the Health Board to conclude its Confidential Investigation and to formulate an Action Plan as this was not completed until the 27th April 2018, some four months after Mr Welton's death.

I am further concerned that notwithstanding that an Action Plan had been established with agreed timescales for implementation of actions, these timescales have not been met and matters remain outstanding at the present time.

Whilst this investigation and report relates to the death of Mr Welton, I am concerned generally by the length of time which is taken by the Health Board to conclude its Serious Incident Reviews and thereafter to formulate and implement Action Plans."

The current process
The Concerns Procedure (PTR01a) outlines and guides staff in the management of incident investigation. Once an incident is identified staff should take immediate action to ensure the safety of the persons involved, restore a safe environment, preserve evidence and ensure the incident is reported. Where an incident is categorised as either major or catastrophic (where serious alleged harm has occurred) the circumstances surrounding the incident are escalated to senior staff.

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Within 72hrs of the incident being reported an initial review is instigated by the divisional governance teams and includes relevant clinical staff. Remedial actions are re-affirmed and/or further identified and the terms of reference for a comprehensive investigation 'serious incident review' are outlined.

The investigation is undertaken, lead by the Chair and driven by the Investigating Officer, working with a small group of relevant expert staff not associated with the care of the individual. Statements from the staff involved in the care/incident inform the investigation and they also have an opportunity to comment on the draft report.

Currently the Investigation Officers into catastrophic incidents (resulting in death) are drawn from the corporate concerns team. Whilst this has afforded a degree of independence into the investigation process, it has also lead to some disconnect between the service and the investigation team and in some cases, delayed the development of the action plan.

The patient/family are involved to the degree they indicate in line with the Being Open policy. The comprehensive investigation report is approved by the Chair of the panel and the relevant service leads are responsible for developing, implementing, monitoring and evaluating the actions to address the recommendations of the report. The relevant senior manager (likely to be at Director level) would approve the action plan.

The finalised report and action plan is presented to the relevant divisional Quality & Safety Meeting (reporting via the Quality and Safety Group to the Quality, Safety and Experience Board Committee). The local Quality Safety meeting will oversee the implementation, monitoring and efficacy of the actions.
The timescales for the whole process should be no more than 60 working days.

Individual case
In relation to the case of Mr Neville Welton, on reviewing the timeline of investigations/incident reviews the issues that resulted in delays were:

- Chair/panel members did not respond in a timely manner to enable sign off of the draft report
- Legal advice in relation to breach of duty, qualifying liability and causation was required and it was assessed that the report could not be signed off by the Chair until this was received.
- The action plan is developed by the division from the recommendations within the report was delayed

Moving forward
In terms of moving forward a number of actions are being implemented to improve the timeliness of our processes and the development of the action plans:

1. The Health Board is revising the model for the investigation of serious incidents to support the divisions to investigate all incidents including catastrophic incidents. This will create capacity within the Corporate Concerns Teams in order for them to support and train staff in incident management. Each investigating officer for a catastrophic incident would have a member of the Corporate Concerns Team working alongside them to ensure a timely

and robust investigation, that addresses qualifying liability for the start of the process and will also ensure the action pans begins to be developed at the start of the process not towards the end.

The corporate teams would also have the capacity to offer wider training to staff in the investigation process and the management of incidents. The Corporate Concerns Teams would retain the coordination role of the inquests work as is now in order to ensure robust monitoring is in place.

This change will need to be managed over a period of transition but will formally commence as of 1st September 2018.

2. The Health Board is to introduce a weekly Incident Review Meeting (Scoping document Appendix 1) to review on a regular basis all incidents reported on Datix in the previous 7 days. The meeting will be chaired by the Associate Director of Quality Assurance and attended by the senior staff with a specific responsibility for quality and patient safety from each division.

   The standing agenda will review:

   - All new catastrophic and major incidents reported in previous 7 days
   - Update on the previous weeks serious incidents
   - Performance management of incidents which are delayed
   - Inquest scheduled for the coming month (monthly timescale used as need time to ensure preparations are in place in good time)

   The benefit of this approach is to ensure that incidents are classified accurately and that teams allocated to undertaken the review are appropriate, it will also provide senior review of high level incidents. The meeting will require senior managers to provide a summary of all incidents, progress to date in terms of the investigation, learning identified and actions taken to develop, and implement the action plan. The meeting will drive all investigations to completion within the timescales and provide support to manage any challenges that might hamper the progress of the investigation.

   The meeting will be held on a Thursday afternoon commencing July 12th 2018

3. A project management approach to be used when conducting a comprehensive investigation with milestones for completion signed up to by the designated Chair (see appendix 2). This approach is not yet in place and will be implemented as part of the revised model described above.

The Health Board is committed to improving the learning from incidents and a timely and robust investigation is key to this. We believe that the implementation of the actions above will lead to significant improvement. These measures will take time to fully embed and the actions will be closely monitored at both the weekly review meetings and reported monthly to the Executive led Quality and Safety Group.

If you require any further information or wish to discuss this please do not hesitate to contact me.

Yours sincerely

Mrs Gill Harris
Executive Director of Nursing and Midwifery on behalf of the Chief Executive