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Cardiff and Vale University Health Board

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Ein cyf/Our ref: LR-jb-03-7330
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Len Richards
Chief Executive

11 March 2019

Mr Andrew Barkley
Her Majesty's Senior Coroner
South Wales Central Coroner Area
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

Dear Mr Barkley

Touching upon the death of the late Mr John Preece

Thank you for your letter which we received on 16 January 2019. The University Health Board (UHB) has reviewed the points raised within the Regulation 28 report with relates to the very sad death of Mr Preece. Our response has been informed by key clinical staff within Mental Health Clinical Board.

We recognise that this will have been a very difficult time for Mr Preece's family and would like to offer out most sincere condolences. The matter has been fully investigated and there is a comprehensive improvement plan in place which is being monitored by the Clinical Board.

For ease of reference, I will respond to each of the matters of concern you have raised in turn.

1. **There was a clear lack of understanding and basic knowledge of falls management in both trained and support workers in circumstances in which it should have been obvious that Mr Preece sustained a head injury. The evidence clearly revealed that there was knowledge of a head injury following his seizure and fall. Even if that were not the case a head injury should have been suspected.**

Mental Health Clinical Board run a bespoke falls training programme which has been developed by the Practice Nurse Educators within the Mental Health Services for Older People (MHSOP) Directorate. The sessions specifically include training on falls risk management (to identify measures to reduce the risk of a patient falling), post falls management, responding to an unwitnessed or witnessed fall and performing neuro observations. This training is delivered on a rolling programme and so far, approximately 75% of nurses (both qualified and unqualified) within MHSOP

and Adult Mental Health have attended this training. 37 out of 42 nurses working on St Barrac's ward have completed this training and arrangements are in place for the outstanding 5 nurses to attend training soon.

The UHB has recently opened a falls simulation training suite in the University Hospital of Wales (UHW) and there are plans for a further suite to be sited in University Hospital Llandough. All qualified and support staff are encouraged to attend simulation workshops on falls prevention management and post fall care. The training covers the management of an unwitnessed fall including how to respond to a head injury.

One of the Nurse Advisors for Standards and Professional Practice is currently working a day a week with nursing staff in MHSOP reviewing patients who have been assessed to be at high risk of falling. The purpose of this work is to try and identify other preventative measures to further reduce the risk of falling.

2. **There was a clear lack of knowledge amongst all staff, both registered nurses and support workers as to how to conduct neuro observations despite the evidence showing that guidance in the form of health board policy and also a "wall chart" was available to be consulted.**

Training on neuro observations is included in the bespoke Mental Health training programme and also in the UHB wide falls simulation training.

A new neuro observation chart was introduced in August 2018 and it is now UHB policy that only registered nurses perform this task.

3. **There was no forward planning for the continued observations of Mr Preece throughout the day on 9th September 2015 and as a result he was simply put to bed and not closely monitored as the circumstances required.**

There are clear escalation processes in place and our internal investigation identified that 2 nurses did not follow this process. They were managed by UHB disciplinary procedures and have now been referred to the Nursing and Midwifery Council for further investigation.

4. **The evidence revealed that none of the registered nursing staff were trained either during their basic nurse training or subsequently upon employment within the health board, on how to conduct neuro observations and that together with a failure to appreciate an obvious head injury meant that not only observations conducted but that no medical assistance was sought for at least 10 hours.**

In 2015 undergraduate nurse training did not cover how to perform neuro observations but this task has now been added to the curriculum and as mentioned above, training on how to perform neuro observations is now included in falls training within the UHB.

5. **Evidence given at the inquest showed that the health board had considered the introduction of the NEWS scoring system (National Early Warning System) for the Mental Health Directorate but felt unable to introduce it as the mental health unit did not sit within/alongside a district general hospital. The obvious concern being that against a background of poor training and poor management medically unwell mental health patients are at risk.**

St Barruc ward is part of Barry Hospital which is not attached to one of the UHB's main hospital sites. Barry Hospital is a community hospital with in-patient wards and other community out-patient services.

MHSOP Directorate are not able to guarantee the level of medical cover at Barry Hospital (there is no 24 hour medical cover) hence it has not been possible for the NEWS monitoring system to be implemented there in the same way as it has been implemented in the district general hospitals where medical staff are available on-site at all times. MHSOP have therefore introduced an escalation policy specifically for St Barruc ward covering in and out of hours. This policy gives nursing staff guidance on who to contact for medical advice and who to escalate any concerns to.

NEWS is used across MHSOP wards based in University Hospital Llandough to assist nurses and medical staff in determining the degree of illness of a patient and again there are clear escalation policies in place, if nurses identify a patient whose NEWS score is deteriorating or if they have general concerns.

I hope that the information set out in this letter provides you with the assurance that the Health Board has fully considered the issues raised as a consequence of the inquest into Mr Preece's death, and has taken appropriate action in response.

Yours sincerely

L. Richards

Len Richards
Chief Executive