Dear Mr Gittins

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Hannah Elizabeth Browning (DOB 18.4.96 DOD 12.10.18)

This report has been developed in response to the Coroner's issuing of a Rule 28 jointly to Wrexham County Borough Council Social Services department and Betsi Cadwaladr University Health Board (BCUHB), following the Coroner's inquest into the death of Hannah Browning, which concluded on the 12th April 2021.

The Local Authority would like to offer their sincere condolences to the family of Hannah on their tragic loss.

Response

In response to the concerns raised by the coroner in relation to the inquest of the death of Hannah Browning the following actions have been taken in May 2021 to address and manage the areas of concern identified by the coroner, including communication and crisis planning.

Actions to Date – development of a checklist. (Please see Checklist attached as Appendix 1)

1. The Local Authority has developed a social work checklist for all open and active cases to the mental health social work team and for all duty cases where the social worker is the designated daily duty worker in Ty Derbyn. This procedure has been developed to provide clear guidance to social workers regarding the local authorities' expectations of them in their social work role and to ensure that all social workers are aware of the process that needs to be followed in the event of a similar situation to that which occurred with Hannah Browning.

2. This checklist will be given to the social workers in a word document format with a check box which will need to be completed, the social worker will also sign and date and time the document. The document will be attached to the individuals' case record (currently a paper file) for each occurrence where the social worker has identified risks or concern regarding a person's wellbeing or welfare or where a duty assessment has taken place. Where a case needs to be escalated to the daily AM or PM Community Mental Health Team safety huddle due to concerns or risks to the person's welfare or wellbeing (point 3 below), the social worker will scan a copy of the checklist and email the relevant duty manager with a copy. The social worker will also hand a paper copy to the daily duty manager as soon as the social worker identifies concerns/ risks, if the social worker is not in the building when the concerns are identified then telephone contact must be made with the duty manager immediately. The daily duty manger is one of 3 team managers or equivalents (deputy county managers Betsi Cadwaladr University Health Board post) within the Community Mental Health integrated team and will take responsibility for the safety huddle (see 4 below)

3. Duty assessments and Case check list: is a clear step by step approach of what actions are needed and required when managing or dealing with duty cases as well as social workers own cases. The check list is a 6 step approach and prompts social workers to act, plan, record and communicate all risks and concerns to the safety huddle duty manager (as outlined in paragraph 2) and subsequently the case record. The 2 points below which are steps 5 and 6 of the procedure clearly identify what specific actions need to be taken without delay and as a priority when a person, known or open to a social worker, indicates or identifies that they intend to harm themselves. These steps also reflect the areas of concern identified by the coroner; communication and crisis planning.

    - Any disclosure of overdose/self-harm, social workers to ensure there is clear plan of how this is being managed to reduce risks and make appropriate referrals to Duty Manager, on-call Consultant, HTT, AMHP and update Health Liaison team/Emergency Duty Team with any relevant information for out of hours.

    - Where an individual states that they intend or plan harm to themselves and leave a meeting or discussion prematurely the social worker will not delay in escalating this to the daily duty manager (for BCUHB Safety huddle process to be followed), the social worker will also attempt immediate telephone contact with the individual and continue to attempt contact until the safety huddle duty manager has been handed the checklist and information and has agreed that they will escalate it to the agreed agencies.

    The Local Authority believe that the measures taken above provide a clear and robust procedure for social workers within Community Mental Health Team to follow if a person they are supporting or assessing presents as a risk to themselves or the social worker believes that there is any intention to self-harm.

4. BCUHB implementation of an additional Safety huddle**.** A morning safety huddle is already in place, BCUHB have developed a further safety huddle at the end of each day (4.30pm) which::

    - Ensures that the duty manager is appraised by ALL team members of any ongoing concerns for consideration at the Safety huddle
    - Chair will ensure that the huddle discussions are appropriately minuted, and all agreed actions are clearly identified
    - Will discuss all known heightened and / or unmitigated risk
    - Will identify solutions or mitigation plans for the proceeding out of hours period to maintain patient and staff safety and ensure handover outcomes to the next morning Safety huddle
    - Will ensure all local out of hours teams eg Emergency Duty Team (EDT)/ Home Treatment Teams (HTT) / Psychiatric liaison/ Inpatient duty nurses / on call medical staff are aware of risk

issues and fully engaged in formulating management plans for the out of hours period
- Will escalate and alert the tactical on call system (bronze, silver, gold) and EDT, of any heightened or unmitigated risk including solutions where possible

All of the above actions have been shared with the Community Mental Health Team Social work team manager who has disseminated these to all social work staff within the team. In addition to the above actions the below actions are planned over the time period identified below.

Future Planning

Actions Planned for development over the next 6-9 months include:

- The development of Local Authority policies and procedures including
- Mental Health policy
- Escalation policy
- Risk management process and policy (this will include crisis plan
- Pathway procedures (WCBC & BCUHB)
- Reporting and recording procedures (WCCIS)

The above actions I believe demonstrate the joint commitment by both organisations to put measures in place to prevent a similar incident occurring in the future. The learning outcomes from inquest have enabled Social Services to review and reflect on previous, current and future practices, specifically communication and crisis planning and to implement prevention strategies as identified in this report.

Appendix 1

Checklist for Duty

This checklist is to be used by all social workers, where risks of potential harm to the person or potential harm towards others, has been identified.

The local Authority has developed a social work checklist for all open and active cases to the Community Mental Health Social Work Team and for all duty cases where the social worker is the designated daily duty worker in Ty Derbyn.

This procedure has been developed to provide clear guidance to social workers regarding the local authorities' expectations of them in their social work role and to ensure that all social workers are aware of the process that needs to be followed in the event of risks being identified of potential harm to the person or potential harm towards others.

Name: **Date:** **Time:**	**CRN:** **Address:** **Contact Number:**
1,Background checks: Is the person open/known to PCMHT/CMHT, if current/previous involvement with team, review all documentation prior to the duty assessment. If open case, please record the information and refer to the relevant practitioner.	
2, Assess/Update: If the person is known to the team and there is no active practitioner involved or the practitioner is off site, ensure any existing documentation is updated even if there are no changes. Following the assessment, ensure Part C formulation is completed and a signed copy is given to the person and a copy for file. Update duty log on share-point.	
3, Record / Share: If the person is open to PCMHT or awaiting	

appointment, record all relevant information, if risks are identified, duty process to be followed. If none are identified and it is information only, record all relevant information and handover to appropriate PCMHT practitioner or manager. Update duty log on share-point.	
4, Record/ Share: If person is not known to team, complete all measures documentation; record any risks that are identified; complete the Part C formulation ensuring a signed copy is given to the person and a copy on file.	
5, Plan/ Share/ Communicate: Any disclosure of overdose/self-harm, please ensure there is clear plan of how this is being managed to reduce risks. Make appropriate referrals to the Duty Manager who will report to the daily Huddle. If further advice/support is needed, discuss with Consultant or on-call Consultant, HTT, AMHP ect and update Health Liaison team/Emergency Duty Team with any relevant information for out of hours.	
6, Escalate/ Communicate: If the person states that they intend or plan harm to themselves and leave a meeting or discussion prematurely the social worker will not delay in escalating this to the Duty Manager (for BCUHB Safety huddle process to be followed). The social worker will also attempt. Immediate telephone contact with the individual and if needed, their carers/family and continue to attempt contact until	

the Duty Manager/ Safety Huddle agree further that they will escalate it to the agreed agencies.	
Social Worker Name and Signature	