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

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Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

John Gittins
HM Senior Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin LL15 1YN

[redacted]

Dyddiad / Date: 26 July 2023

Dear Mr Gittins,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Andrew John Shambrook

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 31 May 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Andrew Shambrook.

I would like to begin by offering my deepest condolences to the family and friends of Mr Shambrook for their loss.

In the Notice, you highlighted your concerns that the health board has no documented or robust policy in relation to decision making criteria and thereafter, future treatment and care pathways when a patient is referred to the Home Treatment Team (HTT).

In response to the Notice, I requested our Mental Health and Learning Disability Division (MHLD) to carefully consider your concerns and provide details of their plans to make our services as safe as possible, taking into account the learning from the inquest.

Firstly, I can confirm that there is an approved Home Treatment Team Operational Policy (MHLD 0035) that has been in use since April 2018. However, this operational policy has exceeded its review date and we are progressing this through the review and ratification process as a priority.

The policy will be reviewed by a working group of key stakeholders, to include home treatment team managers and key clinicians, led by a senior manager. As part of the process of reviewing the Home Treatment Team Operational Policy, the reviewers will be provided with your comments and instructed to ensure that these are fully taken into account.

Once the review is complete, the revised policy will be subject to a period of consultation and will then proceed through the ratification process. Progress on the review and ratification process will be monitored by the divisional policy and procedure development subgroup and any potential delays will be escalated to the divisional senior leadership

team. Assurance will be provided on a monthly basis to the corporate regulatory group. I expect this process to be complete by 31 January 2024 and I will be happy to share with you a copy of the refreshed policy at that time.

As an interim measure, MHLD have provided an addendum to the policy to ensure the concerns noted at the inquest are addressed. The addendum to the Policy will be shared across MHLD to ensure that there is consistency across all areas and I have enclosed a copy of this for your reference.

I hope this letter sets out for you the actions we have taken to ensure the concerns raised by yourself and Mr Shambrook's family are being addressed.

We would be happy to meet with you further and discuss our plans in more detail, or provide further information and assurance should that be helpful.

Once again, I offer my deepest condolences to the family and friends of Mr Shambrook for their loss.

Yours sincerely

[redacted]

[redacted]
Cyfarwyddwr Meddygol Gweithredol / Dirprwy Prif Weithredwr Dros Dro
Executive Medical Director / Acting Deputy Chief Executive

cc [redacted], Executive Director of Public Health
[redacted], Deputy Director of Quality