Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Bloc 5, Llys Carlton, Parc BusnesLlanelwy,
Llanelwy, LL17 0JG

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

Kate Robertson
Senior Coroner for North West Wales
HM Coroner's Office
Shirehall Street
Caernarfon
Gwynedd LL55 1SH

Dyddiad / Date: 31 July 2023

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Eifion Wyn Huws

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 08 June 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Mr Eifion Wyn Huws.

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

In the Notice, you raised a number of concerns.

In response to the inquest and 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. The findings of those considerations and our actions are detailed below.

The Welsh Government have advocated the use of an information technology (IT) system that links health and social care through the use of an integrated care platform. The Welsh Community Care Information System (WCCIS) will enable a single integrated health and social care record. This system will help social services (adults & children) and a range of community health services (including mental health, therapies and community nursing) to ensure that care and support for individuals, families and communities are more effectively planned, co-ordinated and delivered. It will support information sharing requirements, case management and workflow for health and social care organisations across Wales. It will show where a patient is within their treatment journey and alert health professionals to key data, which will support the delivery of effective treatment. WCCIS will interface with a range of other appropriate systems across local authorities and NHS organisations wherever a patient is treated, in their own home, in the community or in a hospital.

Our MHLD Division engagement in the WCCIS Project is ongoing, however its implementation has faced national delays. The Health Board WCCIS Project Team engaged with MHLD services to review system functionality and identified that further

national development work was required to meet our requirements. This work has been ongoing in parallel and conjunction with all Health Boards in Wales. The Health Board's implementation of WCCIS is monitored organisationally through the WCCIS Project Board.

With regard to the investigation report and action plan into the care and treatment delivered to Mr Huws, the benefits of an integrated IT system should have been considered with reference to the implementation of WCCIS within the action plan and this has been discussed with the investigating officer.

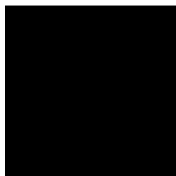
I would like to sincerely apologise for the delays in the completion and timeliness of the investigation report and the implementation of the subsequent action plan. I have acknowledged before, in a previous letter to you, the unacceptable impact on patients, families and the coronial process from delays in investigations and actions plans and I remain firm in my commitment to improve our responsiveness.

In my previous letter to you on 09 May 2023, I was able to inform you of the changes that have taken place within the Health Board; these included a review of the incident process, and the quality control process delivered by the quality governance teams. The Health Board have also implemented rapid learning panels and incident learning panels. The MHLD Division have prioritised the completion of overdue investigations and action plans and there has been a significant reduction in the number overdue. The Division continues to meet weekly to address any remaining overdue investigation reports and to ensure that actions are monitored for completion. I recognise the importance of ensuring this improvement is maintained and I am assured that we have the mechanisms in place to monitor this and to take further action as required.

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

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

Yours sincerely



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

cc ██████████, Executive Director of Public Health
██████████, Deputy Director of Quality