



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

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

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

Kate Robertson  
Assistant Coroner  
North Wales (East and Central)  
Coroner's Office  
County Hall  
Wynnstay Road  
Ruthin LL15 1YN

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

**Dyddiad / Date:** 12<sup>th</sup> September 2023

Dear Ms Robertson,

## **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS Emily Corfield**

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 16 July 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest into the death of Emily Corfield.

I would like to begin by offering my deepest condolences to the family and friends of Ms Corfield for their loss, and to apologise to them for the failures that were identified during the inquest which led to your notice.

In the notice, you highlighted your concerns that Ms Corfield had not received input from the alcohol liaison service when an inpatient nor in the community and that you were not assured of the Health Board processes to ensure that referrals to the service are acted upon.

In response to the notice, I requested our Mental Health and Learning Disabilities Division (MHLDD) consider your concerns and provide details of their plans to make our services as effective as possible, taking into account the learning from the inquest.

Firstly, I can confirm there is a Mental Health and Learning Disabilities Liaison Psychiatry Services in Acute Hospitals Delivery Framework (MHLDD AC001) that is within date and available on the Intranet for all Health Board staff to access. This document outlines the services provided by Liaison from a multidisciplinary group of staff and includes alcohol liaison staff. The referral process to liaison services is detailed within the framework.

During consideration of your concerns, it was identified that the liaison service did not receive a referral from the treating team located in our Integrated Health Community (East). In response to this, a communication has been produced that outlines the referral process to liaison services that will be shared with clinical teams across the Health Board to ensure there is clarity and consistency across all areas. This communication has now been issued.



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Although in date and operational, the MHLD Liaison Psychiatry Services in Acute Hospitals Delivery Framework will be reviewed by a working group of stakeholders, to include liaison team managers and key clinicians, led by a senior manager to ensure the referral process is clear and unambiguous.

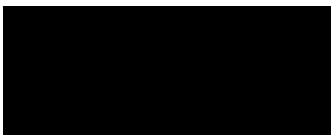
Once the review is complete, the revised framework will be subject to a period of consultation and will then proceed through the ratification process. Progress on the review and ratification process will be monitored by the Divisional Policy and Procedure Development Subgroup and any potential delays will be escalated to the Divisional Senior Leadership Team.

I hope this letter sets out for you the actions we have taken to ensure the concerns raised by yourself 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 Ms Corfield for their loss and I reiterate my sincere apologies to them for the concerns identified at the inquest.

Yours sincerely,



**Prif Weithredwr Dros Dro**  
**Interim Chief Executive**

c.c. , Interim Deputy Chief Executive and Executive Medical Director  
, Executive Director of Public Health (Executive Lead for Mental Health)  
, Deputy Director of Quality