Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

[redacted]

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

Pencadlys Bwrdd Iechyd Prifysgol Bae Abertawe
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Dyddiad / Date: 27th September 2023

Mr Aled Gruffydd,
Assistant Coroner – Swansea and Neath Port Talbot,
The Guildhall,
Swansea,
SA1 4PE.

Dear Mr Gruffydd,

RE: REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Further to your notification of a Regulation 28 Report following the inquest of Shane Luke West, Swansea Bay University Health Board is now able to provide a response on actions it intends to take to prevent future deaths.

At the outset, I would like to thank His Majesty's Coroner for the 2-week extension provided to the health board, to respond to the report. The extension allowed the health board to provide 6 weeks' notice to clinical colleagues of a "Significant Case Review" meeting, enabling a multi-professional approach to the review of the case, the concerns highlighted within the report and to identify opportunities for prevention and improvement.

The matters of concern highlighted within the report formed the agenda of the meeting. Please note the following outcomes and actions agreed:

1. **There was a contradiction between the nursing notes and the prescription charts as to the amount of laxatives administered on the 15th and 16th August 2018.**

   The death of Shane on 17th August 2018, was identified as an adverse incident by the health board and notified as a nationally reportable serious incident to Welsh Government [redacted].

   The health board acknowledged that in setting out the scope of its Serious Incident Investigation the administration of prescribed laxatives was not perceived to have been an issue at the time. Consequently, it was not included in the scope and was not highlighted as a problem during the investigation. It was therefore a missed opportunity to review the contradiction highlighted within the Regulation 28 Report.

   Action1.1: Amend the health board's Serious Incident strategy meeting template to include an explicit question on whether medication (prescribed and/or administered) was a feature within the incident.

   The Health Board currently uses a template document to support the agenda of its Serious Incident Strategy Meetings. The aim is to provide a consistent checklist for setting the scope and lines of enquiry the serious incident investigation process and ensure that key aspects of healthcare provision and key stakeholders are identified.

   The template will be updated with an explicit question on the involvement of medications from 1st October 2023.

   Action 1.2: Swansea Bay University Health Board is currently implementing a Hospital Electronic Prescribing and Administration of Medicines (HEPMA) system.

   HEPMA is an electronic prescribing system that replaces paper-based prescribing is expected to improve the quality of prescribing and a reduction in drug administration errors.

   HEPMA is being implemented at Morriston Hospital as part of a structured programme, which is expected to be completed by March 2024.

2. **Shane was known to hide his physical condition on questioning due to his learning disabilities and saying what he thought people wanted to hear. As such it was difficult for staff to get a true picture of Shane's condition.**

   All professionals attending the "Significant Case Review" meeting agreed that the development of a constructive, mutually beneficial relationship between the clinical team and patients with complex needs is key to keeping the patient safe and achieving positive clinical outcomes.

   It was acknowledged that the resources to achieve this goal are currently limited. At the time of writing, Morriston Hospital has only one dedicated Learning Disabilities Nurse, providing specialist input from Monday through to Friday. It is therefore important that those patients who are likely to benefit most from the service use this resource effectively and efficiently.

Action 2.1: Development and implementation of a Standard Operating Procedure (SOP) for the multi-disciplinary management of patients with complex needs following an emergency admission to acute hospital care.

The intention is that when an agreed explicit length of stay trigger had been reached, a multi-disciplinary meeting would be called to consider all aspects of care delivery for a patient with complex needs. This approach would ensure a clear focus is maintained on the individual and ensure that specialist clinical knowledge is pulled together into a single clinical management plan, which is shared across multiple professions.

A draft "standard operating procedure" will be developed for consideration by 31st December 2023.

Action 2.2: Risk assessment to be undertaken on the provision of specialist Learning Disabilities nursing resource at Morriston Hospital to support compliance of Regulation 28 Report (issued July 2023)

It is recognised that a single-handed learning disabilities resource is insufficient for the needs of Morriston Hospital. In addition, changes to emergency patient flow as part of the health board's Acute Medical Service Redesign, will mean that all patients with complex needs requiring emergency admission will usually be admitted to Morriston Hospital.

The assessment will need to consider actual service demand across the health board by the Learning Disabilities Service and an assessment of the gaps in service provision, thereby supporting the improvement work described in this response.

A risk assessment will be presented to the health board's risk scrutiny panel, by 30th November 2023 for consideration of inclusion on the health board's risk register.

Action 2.3: Review of current Learning Disabilities training programmes to ensure fitness for purpose and are accessible to staff.

The current training that is offered to all staff in the health board is the Paul Ridd foundation training which has been developed by Swansea Bay University Health Board. The title of the course is "000 NHS Wales – Paul Ridd Learning Disability Awareness Training" and is accessible via the "Electronic Staff Record" system that is available to all employees.

3. **Shane had an ongoing respiratory compromise due to his abdominal distension pressing against his diaphragm therefore further distention posed a risk of further loss of respiratory function.**

   And

4. **It was not clear whether medical professional appreciated this risk and whether the administration of the laxatives ought to be staggered to allow Shane to receive the prescribed dose but not to the extent of overloading his already distended abdomen with fluid.**

It is anticipated that Action 2.1 (described above) will address, as part of an explicit clinical management plan, all clinical issues that emerge throughout the patient's treatment. Should the plan need to be changed it would be through a multi-professional basis, accessing specialist clinical knowledge.

Action 3.1: All staff that prescribe medications are to be reminded that the correct drug needs to be selected, dispensed, and administered in line with National Institute for Health & Care Excellence (NICE) and British National Formulary (BNF) Guidelines.

Linked to Action 1.2, above.

An adult 'faecal impaction' (8 sachets) of macrogol was prescribed in addition to the regular doses of the same. Increased staff awareness of the safe maximum dose of this drug (8 sachets per day) will be reinforced and increasing the level of scrutiny of dosage by the ward pharmacists.

Action 3.2: All staff prescribing medications to be reminded of the importance of reporting adverse reactions to medication (Yellow Card System)

Given that it has been concluded at the inquest that Shane's death was linked to the use of the laxative, this event has been reported nationally via the "Yellow Card" scheme (Yellow Card report: GB-MHRA-MED-20230927110044329O-ZMNCY).

I am confident that the changes described above address your concern; however please do not hesitate to contact me if you require any further information.

Yours sincerely,

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Interim CHIEF EXECUTIVE