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

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

Dyddiad / Date: 10 October 2023

Dear Mr Gittins,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Malcolm Ralph Unwin

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 17 August 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Mr Malcolm Unwin.

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

In the Notice, you highlighted your concerns that the bed rail assessment is not part of the new national Welsh Nursing Care Record (WNCR) system and as such completion of this form may be missed.

In response to the Notice, I requested our senior nursing leads to carefully consider your concerns and provide details of the plans to make our services as safe as possible, taking into account the learning from the inquest.

As you know, the WNCR was created by Digital Health and Care Wales working with nurses and other colleagues across NHS Wales to create a digital system with standardised nursing documentation.

The WNCR has been rolled out across all inpatient services in the Health Board, except one community hospital in our west area which will soon be finalised. Additionally, in June of this year we successfully migrated to a single instance of the system across all services in North Wales.

As part of the move to WNCR, national nursing standards were necessary to address the document duplication and inconsistencies in nursing records across Wales. Key to the development of these standards was organisational and multidisciplinary collaboration across NHS Wales.

All standards were supported by a governance assurance process, which incorporated end to end nursing governance that included specialist nurses and current best practice evidence recommendations from multidisciplinary specialist groups.

As you identified, the bed rails assessment has not yet been through the nursing standardisation and governance process meaning there is not yet a single version to be incorporated into this national system.

Following your Notice, we raised this issue nationally in order to expedite this process. The issue was discussed at the National Deputy Directors of Nursing Meeting on 07 September 2023, and in response Cwm Taf Morgannwg University Health Board has taken the lead in establishing a national working group to create a standardised bed rails assessment tool across Wales, and to propose this single version for inclusion in the WNCR.

As this is national, collaborative work involving all Health Boards and Trusts in NHS Wales then I cannot advise a specific completion date. However I can confirm that this will remain open on our action tracker and should the matter be delayed, it will be escalated for executive director intervention.

We have also added this issue to our risk register until the transition to the WNCR is complete. This risk will be owned by our patient safety team and senior nursing team which will ensure the issue, and the risk to patient safety, remains visible until the national work is complete.

In the interim period, I can confirm we have written to all ward managers, matrons and heads of nursing reminding them of the process for paper based assessment forms. We have provided information which can be used on ward safety briefs with staff and which can also be visibly placed in wards to remind staff.

We are also in the process of finalising our updated Bed Rails Procedure which will be live within the next few weeks.

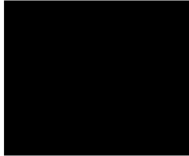
Finally, I would also advise that the Welsh Government (WG) and the Medicines and Healthcare products Regulatory Agency (MHRA) issued a National Patient Safety Alert on 30 August 2023 which includes safety considerations around bed rails. We are currently working through the actions required to comply with this alert and developing our response, which requires actions to be completed by 01 March 2024.

I hope this letter sets out for you the actions we have taken to ensure the concerns you raised 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 Unwin for their loss.

Yours sincerely



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

cc , Deputy Director of Quality