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

Dyddiad / Date: 30 October 2023

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Lynsey Sarah Smalley

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 08 September 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Ms Lynsey Smalley.

I would like to begin with offering my deepest condolences to the family and friends of Ms Smalley.

In the notice, you highlighted your concerns that there were three investigation reports into the care and treatment provided to Ms Smalley and the length of time it took to propose actions for improvement and complete said actions.

In response to the Notice, I asked our Mental Health and Learning Disabilities Division (MHLD) to consider your concerns and provide details of their plans to ensure timely progression of investigations and action plans.

The MHLD Division have reviewed the investigation reports for Ms Smalley and I have listed these below in date order for ease of reference:

On 09 August 2021, an initial investigation report into the care and treatment provided to Ms Smalley was shared with the Coroner's office. The author of this report was Iolo Jones. The reference for the report is INC258782. The report was finalised on 26 May 2021.

On 27 January 2022, the Health Board received a complaint (reference COM52706) from Mr Andrew Smalley raising concerns about the care and treatment of Ms Smalley. A decision was made to reinvestigate the care and treatment provided to Ms Smalley and an investigating officer from the MHLD Quality Governance Team was allocated.

In May 2022, the new investigation report (COM52706), was shared electronically with Mr Smalley. This report had a date of 04 April 2022. The report was shared with Mr

Smalley so that he could review it before a planned meeting on 23 May 2022 with the investigating officer and a member of the MHLD Senior Leadership Team (SLT).

After the meeting with the investigating officer and a member of the SLT, Mr Smalley returned the investigation report (COM52706) to the Health Board with additional questions and requests for clarifications highlighted in bold red. The investigating officer agreed to address the additional questions and clarifications within the report which would be updated and re-sent to both Mr Smalley and the Coroner's Office.

The final report that answered the additional questions and clarifications submitted by Mr Smalley was shared with the Coroner's Office on 6 April 2023. This has an additional ID number of ID346, which reflects the migration to the new "Once for Wales" Datix system (which we use to log and manage incidents and complaints). This has a date of 13 January 2023 as the date the author concluded the report. This final report has additional actions to the first report (INC258782) completed in 2021 and these additional actions were completed between April 2023 and August 2023.

I share your concerns about the length of time between Ms Smalley's death and the completion of all actions identified in the investigation reports that were shared with you and Mr Smalley. I would like to take this opportunity to reaffirm our commitment, to you and the family and friends of deceased patients, to implement systems that enable us to identify improvements in a much timelier manner.

The Health Board is now fully reviewing the incident process to identify where it can be improved and strengthened. A workshop was held on the 23rd October 2023 to identify current issues and to begin the work of revising our process. The concerns you have identified in this notice, and in other notices, are being directly fed into this work. We are working in co-designing the process with staff and patient representatives, such as the independent Llais organisation, to implement a completely new and improved approach where the focus is on learning and improvement. During November 2023 we are meeting with the IHCs and Divisions for their collaboration and engagement in developing the process. The draft process will be submitted for review at the Health Board Patient Safety Group in January 2024 then ratified in Quality and Safety Executive Committee for a planned launch in April 2024 (which reflects the need to co-design our process, implement new systems and train staff I hope this gives you assurance that we are listening to your concerns and plan to make significant improvements to our processes and ways of working.

Within the MHLD Division specifically, there have been a number of changes to strengthen the existing governance processes that underpin the management of action plans for improvement.

The progress of reviews of incidents and complaints, and action plans arising from completed reviews, are monitored locally at the Putting Things Right (PTR) weekly meeting which is chaired by the Head of Nursing. All incidents, concerns and action plans are also monitored by the Quality Governance team, reporting weekly to Divisional PTR

which is chaired by the deputy director of nursing, and any delays or breaches in timescales are highlighted. In June 2023, the Quality Governance team also began monitoring the receipt of evidence for completed actions via this forum. The Divisional PTR meeting reports to the Divisional SLT on a weekly basis and into the Divisional Quality Delivery Group on a monthly basis escalating any delays in the progress of reviews or actions. The expectation is that all complaints and incidents will be reviewed in line with the timescales set out by The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and any delays are escalated each week to the Divisional SLT.

In addition, the MHLD Division has implemented a Learning and Action Group, the function of which is to support the embedding of learning identified from a variety of sources, including incidents and complaints.

The MHLD Division has a close working relationship with the Healthcare Law Team who coordinate inquest activity for the Health Board. The Divisional Heads of Nursing meet each week with the Healthcare Law Team and the Head of Governance. This has further strengthened the timely submission of reports and evidence of completed actions.

Within the notice, you also raised your continued concerns about the implementation of digital patient records for MHLD. In previous correspondence with you, the Health Board has reported significant delays with the development and implementation of a suitable system at a national level. I understand that you have raised your concerns about the delays with the Health Minister directly. We now know that following a decision made by WG the national system will not be progressing in the way that was previously expected. This has significantly altered MHLD divisional plans for digital transformation as these were dependent upon the use of the WCCIS Care Director Version 5 product, with a pilot having been due to start in September 2023, and the expectation that a wider adoption across all applicable MHLD services would follow. Regional meetings are now taking place across Wales to discuss the options that have been presented to them by WG as alternative to WCCIS Care Direct Version 5. BCUHB has met with Local Authorities to discuss implications across health and social care services in order to come to an agreement on the preferred option for North Wales.

In addition I am pleased to report that a Strategic Outline Case for an Electronic Patient Record system(s) is being developed on a Health Board wide level to address the issue of fragmented care records; the deadline for the strategic outline case is the end of January 2024. MHLD are taking a key role in shaping the outline case to ensure that the Division's needs are considered as part of the Health Board wide proposal.

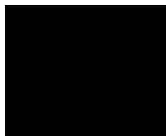
Whilst MHLD are keen to support and progress the processes outlined above, we are mindful of the scale of the task for agreeing a national solution and are therefore working with BCUHBs Chief Information Officer to consider options which may bring MHLD a more timely solution. This remains a major priority for the Division and is supported by the Health Board.

I hope this letter sets out for you the actions we have taken to ensure the concerns you raised are being addressed. In particular, I want to assure you we are listening to your concerns around investigations and plan to undertake a significant piece of work as outlined above to make long term, substantial changes.

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 Smalley 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 (Executive Lead for Metal Health)
, Deputy Director of Quality