Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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

[redacted]

Dyddiad / Date: 3 November 2023

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Richard Geraint Griffiths

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated the 14th September 2023, issued by yourself to Betsi Cadwaladr University Health Board following the inquest of Mr Griffiths.

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

In the notice, you highlighted your concerns that the Health Boards investigation into the care and treatment provided to Mr Griffiths was not of the expected standard.

In response to the notice, I asked our Mental Health and Learning Disabilities Division (MH&LD) to consider your concerns and provide details of their plans to ensure the provision of robust investigation reports and action plans for improvement.

[redacted], the Director of MH&LD Division, reported to you on the 14th September 2023 that an addendum investigation would be undertaken to expand on the pertinent points relating to how the transfer of care of Mr Griffiths did not happen.

The investigation is underway, and the investigating officer (IO) has undertaken interviews with staff directly and indirectly involved in Mr Griffiths' care and treatment. The IO has considered the transfer process that was in place at the time Mr Griffiths was receiving care, the improvements that have been made since, and the review of the Transfer and Discharge of Care Protocol. The addendum report is currently progressing through the Health Board's approval process and I will be happy to share this with you on its completion in the coming weeks.

On the 15th September 2023, the Quality Governance team contacted the Heads of Operations and Heads of Nursing throughout MH&LD to share the concerns you raised about the quality of the investigation report. The Quality Governance team requested that in future, IOs meet with the staff involved in the delivery of care and treatment to explore in detail the decision-making and actions taken when delivering care and that the

outcome of reports are shared with the staff involved. The Quality Governance team now also check for this aspect during the quality assurance of reports. This will ensure more detailed investigations that get to heart of the contributory factors and the root causes of incidents.

The Transfer and Discharge of Care Protocol has been revised to include explicit guidance relating to transfers of care between community teams. This includes the steps to be taken by the care coordinator, supporting administrative staff and the single point of access service (SPOA). Progression of this protocol through the Health Board ratification process is being led by the MH&LD Deputy Director of Nursing and progress is overseen by the MH&LD Policy and Procedure Group. The revised protocol is due at MH&LD Policy and Procedure Group in December 2023 after which it will progress through the Health Boards revised ratification process. I anticipate that the protocol will be ratified by the end of January 2024.

Within the notice, you also raised your continued concerns about the implementation of digital patient records for MH&LD. 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 MH&LD 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 MH&LD 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. MH&LD 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 MH&LD 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 MH&LD 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.

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 Griffiths for their loss.

Yours sincerely

[redacted]

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

cc [redacted], Deputy Director of Quality