Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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

Ein cyf / Our ref:
Eichcyf / Your ref:
[redacted]

Dyddiad / Date: 19 December 2023

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Jennifer Lydia Campbell

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 24 October 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Jennifer Lydia Campbell.

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

In the notice, you highlighted your concerns regarding the lack of an investigation and therefore subsequent learning, the absence of concerns from the medical examiner being acted upon, and the absence of a strategy for introducing electronic patient record systems.

Turning to the first concern, we fully acknowledge that no incident was reported regarding the missing referral form and as such the incident review process did not take place. We are taking steps to ensure staff are aware of the need to report an incident in these situations through awareness and reminders. We are also undertaking a full review of the incident process in the Health Board, in co-design with our staff, and will introduce a new process and procedure for April 2024. This new process will include a revised training programme for staff.

Following this incident, I can however confirm there has been learning and we have made improvements. A new standing operating procedure for all endoscopy referrals has been implemented in November 2023 to ensure all paper referrals are scanned into the endoscopy email inbox, even if received in paper format by the endoscopy booking clerks. An audit has been completed of referral forms dating 01 October 2021 to 30 November 2023 to ensure no other forms have been lost.

In relation to a lack of action on concerns from the medical examiner, whilst I acknowledge your own concerns, the Health Board only received the report from the medical examiner on the day of the inquest as a result of your inquiries (and I understand you are aware of this issue at the inquest). The Senior Medical Examiner Officer for North

Wales has confirmed no scrutiny document was created at the time of the death by them, and therefore the Health Board was not in receipt of the concerns they had. The medical examiner service is independent to the Health Board and provided nationally by NHS Wales Shared Services Partnership. We have reported this issue to them.

We do however accept that we have improvements to be made to our own process, and the West Integrated Health Community have developed and implemented a process in November 2023 to ensure that any complaints, medical examiner reports, incidents and other matters are adequately reviewed to ensure we are able to provide patients and families the best response and outcome, and to ensure lessons learnt are appropriate and shared.

Our new incident process, and the accompanying training, will also stress the importance of triangulating information from all sources during an investigation.

At an organisational level, our Mortality Review Team have developed and introduced a process whereby medical examiner forms are triaged upon receipt and will be sent to our clinical services and uploaded to our Datix quality management system within 2 weeks, ensuring they are available for access by those undertaking investigations. Following this triage, the team will also send a copy to the Patient Safety Team if anything is identified which may need to trigger the incident process. This provides a further safety net and was introduced over the summer of 2023 as a result of your earlier concerns.

In relation to electronic records, we are currently developing a strategic outline business case for an Electronic Patient Record (EPR) system in conjunction with Welsh Government and Digital Health and Care Wales (DHCW). This business case will require significant investment and the Health Board hope to present it to Welsh Government in early 2024 and would expect significant time taken to secure approval. Once funds are secured, the timelines for delivering such a significant transformation project, as is required in the case of the Health Board, will be at least three years. This is based on an independent assessment made of our business need in terms of people, practice and technology by Ethical Healthcare Consulting who have been assisting us with this business case.

As you have identified, there is not an electronic internal referrals system for endoscopy and therefore the Health Board is reliant on paper. A fully functioning EPR would address this and is the long term solution.

The team at Ysbyty Gwynedd have put in place mitigations to ensure, as far as possible, no further referrals are misplaced. This includes scanning of all referrals into the endoscopy email inbox, even if they are hand delivered to the endoscopy booking clerks. Referrals are recorded onto the Welsh Patient Administration System (WPAS) as soon as they are received (including if a referral is rejected so that it will still show evidence that a referral was received and triaged). There is also agreement that no referrals will be given directly to the ERCP coordinator. If they receive one directly, they will hand to the booking clerks to be scanned and recorded as above.

In parallel with the operational work above, the Health Board are working with Digital Health and Care Wales (DHCW) on the development of an electronic form as part of the Welsh Clinical Portal (WCP) that clinicians can use to do an internal referral specifically and exclusively for ERCP. It is not clear when this national work will be delivered and we are chasing them on it.

I hope this letter sets out for you the actions we have taken, and will continue to take, to ensure the concerns you raised are being addressed.

Once again, I offer my deepest condolences to the family and friends of Mrs Campbell for their loss.

Yours sincerely

[redacted]

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

cc [redacted], Chief Digital and Information Officer
[redacted], Deputy Director of Quality