GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

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

[redacted]

Dyddiad / Date: 18 January 2024

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Hazel Pearson

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 23 November 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Hazel Pearson.

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

In the notice you highlighted your concerns regarding inadequate improvements to manage patients with food intolerances and allergies, concerns around the inadequacy of governance and poor investigation processes, and concern that staff may not be aware of when to make a Datix report and how to complete this.

On the first concern, I fully acknowledge that the delays in rolling out the improvements to managing patients with food intolerance and allergies were not acceptable. In hindsight, waiting for an all-Wales training package to be agreed was not the correct course of action and some local in-house training should have been developed. The adoption of an all-Wales approach was to ensure consistency of the message and also as a means of accurately recording compliance rates through the national system, the Electronic Staff Record (ESR), which allows reports to be processed on a monthly basis and appropriate action taken to ensure uptake if training does not meet expectations. Other forms of training were considered at the time but there was not a robust mechanism in place to record those.

In relation to your concern that the training was launched only due to the impending inquest, I can advise the Health Board had been pushing at an all-Wales level some 6 months ahead of the inquest, but I appreciate how that may have looked just before the inquest date.

Following the inquest, further meetings have taken place in December 2023 to communicate the roll out of the red wrist bands, which has now happened via the BetsiNet intranet page accessible by all staff and the training is live, with agreed staff groups being

assigned to undertake this training. This will be mandated for them and will automatically appear on their ESR compliance page. Those staff will be all frontline staff who have an involvement in meal provision, with catering staff having an advanced level of training, which is already in place. In addition, agency staff and students will be required to undertake the training and this has been communicated with the agencies and local universities in January 2024. Training for volunteers is also being reviewed in January 2024, and the necessary training links and materials will be made available for the voluntary staff in February 2024. I have enclosed a copy of the communication to all staff via our BetsiNet intranet.

The documents that underpinned the use of red wrist bands were all agreed and signed off through the relevant governance groups 8-9 months from the task and finish group being established. It is acknowledged that there were gaps in the escalation process from the Make it Safe incident review meetings to the Improving Nutrition, Catering and Hydration Standards (INCHS) Group and the governance structure underneath that group has been reviewed and changes are being made to ensure escalation processes are robust and timely.

Compliance with training uptake will be reviewed initially at the end of February 2024 by the chair of INCHS and thereafter through the INCHS quarterly meetings, with the next one of those in March 2024. Appropriate action will be taken if uptake is lower than anticipated or slower than required through the relevant service leadership teams.

To support ongoing improvement, we are also exploring how the Health Board can access expert advice in relation to compliance. Wrexham Council, acting as the Primary Authority for North Wales, have been providing some formal guidance to the Health Board in relation to food safety, specifically food hygiene. The same arrangement for food standards, where food allergens sits, is not in place. The Health Board are considering commissioning this support going forward and will require some funding to support this. The Local Authority have been providing some advice to the Health Board but not in any formal capacity.

On the second and third points around incident reporting and investigations, I know we have written to you recently regarding these points. To summarise our earlier responses, as you know we are 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 on conducting investigations. A revised training programme for incident reporting is in place for all staff with dates confirmed across North Wales for the next quarter alongside “how to” guides and videos for staff to access at any time via the BetsiNet intranet.

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 Pearson for their loss.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Yours sincerely

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

cc [redacted], Acting Executive Director of Therapies and Health Sciences
[redacted], Deputy Director of Quality

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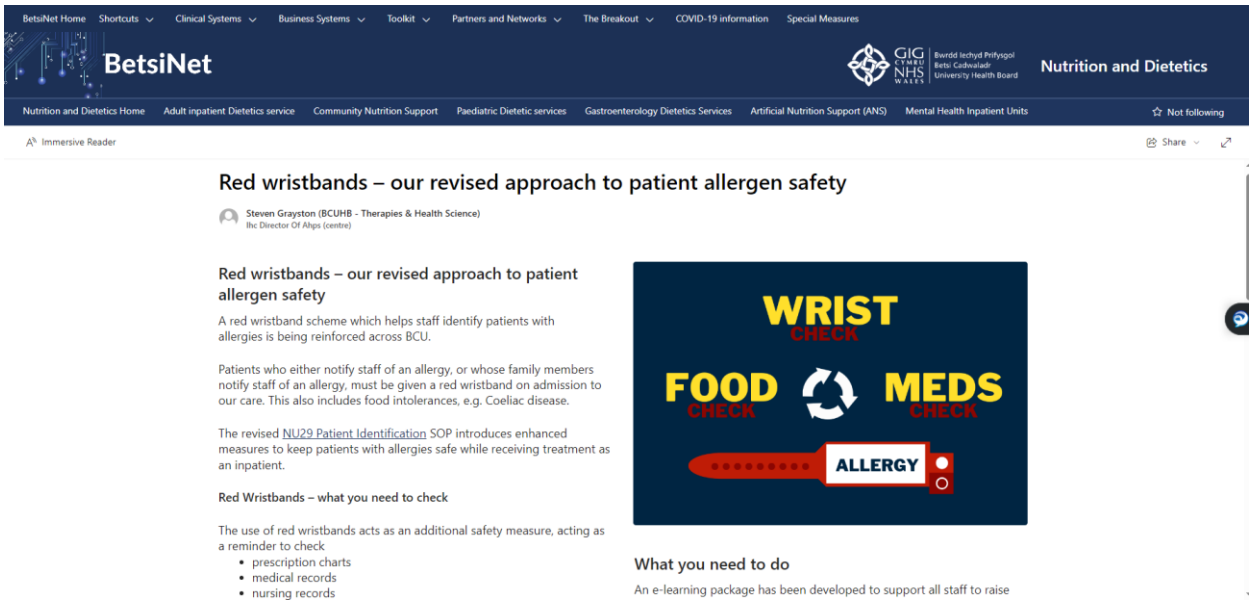
Betsi Cadwaladr
University Health Board

Appendix 1 – Screenshot of BetsiNet staff communication



Appendix 2 – Screenshot of BetsiNet staff communication