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

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

[redacted]

Dyddiad / Date: 18 March 2024

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Thomas Grenville Hammersley Ithell

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 22 January 2024, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Mr Thomas Ithell, who sadly died on 20 November 2022.

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

In the notice you highlighted your concerns as follows:

- *There was no Datix raised by anyone when the error (Mr Ithell being lost to follow up) was identified, either at the time of the appointment on 22 October 2022 when the error was identified or at any point thereafter;*
- *There has been no investigation by the Health Board into how Mr Ithell came lost for follow up after his appointment on 5 November 2021;*
- *There have been no assurances as to what, if any, changes and learning have been identified other than a tracking system for PSA monitoring;*
- *Evidence was heard at the Inquest that time restraints on hospital staff had meant that Datix was not completed and that the system was not user-friendly.*

I will firstly address the concerns around incident reporting and investigation including the Datix system (points 1, 2 and 4 from above).

I can confirm that an Incident Report has now been raised in regards to the error identified and a Make it Safe Rapid Review was undertaken. This review was completed on 05 March 2023. A decision was made to conduct a full investigation and this is underway at present. The incident has been confirmed as a Nationally Reportable Incident (NRI). The investigation report is due to be completed by 09 May 2024 and will include a full action plan to address any areas of learning.

I am aware you have raised your concerns with regards to incident reporting and management previously. Since those earlier concerns, a revised training programme has been put in place for our Datix incident reporting system. This includes training offered by our Quality Systems Team on the Datix system twice monthly, training specifically on incident reporting and reviewing delivered by our Patient Safety Team weekly, and local training delivered by our locally based quality teams (in our East Integrated Health Community for example, there are weekly dates offered). This range of training means there is a mix of opportunities for staff to access training. A number of training videos and "how to guides" are available on our staff intranet.

Another area of concern you have raised previously, and which is relevant here, is the flow of information from the Independent Medical Examiner Service into our incident process. I fully acknowledge this is an areas of concern. As a result of the concerns, the Mortality Review Team have met with the Patient Safety Team and changes are being made. These changes mean that the Mortality Review Team will review every new form with concerns received from the Medical Examiner Services to identify if an existing incident review is underway in which case the records in Datix will be linked and the incident reviewer and divisional leadership team will be notified. If no incident review is underway, the Mortality Review Team will take the concerns to the daily incident review meeting led by the Patient Safety Team at which time a decision can be made to trigger the incident process. This new process is commencing in March 2024 and will be embedded fully into our practice in the coming months, which will ensure the flow of information from the Medical Examiner into the incident process.

I can also advise that the Patient Safety Team have reviewed the incident process and intend to make changes to that process from April 2024. The team have been working with services to co-design the changes taking into account feedback from front line clinicians and looking at best practice across Wales. Over the coming months, we plan further reviews into this process with support from the NHS Wales National Executive Quality Team.

In respect of clinical time, our staff do face significant challenges in balancing all of the required duties whilst providing patient centred care. We are fully mindful of the pressures they face and we will always support them to ensure safety critical tasks are completed. This includes reporting incidents on the Datix system.

The Datix system is a national system, officially known as the Once for Wales Concerns Management System. It is designed and managed nationally in a service hosted by the Welsh Risk Pool, part of the NHS Wales Shared Services Partnership. The current version of the system was implemented in April 2022. The move to a single, national system was an expectation set by Welsh Government. Therefore every member of staff across NHS Wales, in every Health Board and Trust, uses this system.

The design and development of the system has been led an on all-Wales basis and has clinical and non-clinical staff input. Each module, such as the incident module, is aligned to a national network who lead on the design and development of that module and

facilitate any requests for change and enhancement made by staff and services across Wales.

Within the Health Board, in November 2023, we formed a new Quality Systems Group to provide greater oversight of our quality systems in a more integrated approach. This group's remit includes collecting, assessing and acting upon user feedback. Over the coming months we will be conducting a survey of our staff experiences in using the Datix system and we will use these findings to make recommendations nationally on improvements or enhancements to the system (recognising any changes we suggest will be subject to all-Wales agreement).

I will now address point 3 of your concerns, regarding PSA monitoring.

Following the Make it Safe Rapid Review, a number of immediate actions have been agreed. These actions have included validating patients awaiting a clinical decision on the pathway and follow up waiting list.

Awareness of the pathway has also been raised with other specialities.

A suggestion has also been raised with the Digital, Data and Technology Department to consider whether an alert can be built into the electronic patient administration system to identify patients without a follow up appointment.

As mentioned earlier, a full investigation is underway and we expect that a detailed action plan will be developed in response to its findings. This report and action plan will be subject to scrutiny by the East Integrated Health Community directors and will receive final approval and sign off by a Clinical Executive Director.

I hope this letter provides you with the assurance you need that actions have been taken – and assurance that further investigation is underway.

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

Yours sincerely

[redacted]

[redacted] **BMedSci BMBS MRCS DOHNS GDL LLM FRCEM FFMLM MBA**
Dirprwy Gyfarwyddwr Meddygol Gweithredol
Deputy Executive Medical Director

cc [redacted], Executive Medical Director
[redacted], Executive Director of Nursing and Midwifery
[redacted], Deputy Director of Quality