GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

[redacted]

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

Rydym yn croesawu gohebiaeth yn y Gymraeg ac yn y Saesneg.
We welcome correspondence in Welsh or English.

Dyddiad / Date: 16th May 2024

[redacted]

FAO: MR D REGAN
ASSISTANT CORONER

Dear Mr Regan

RESPONSE BY SWASNEA BAY UNIVERISTY HEALTH BOARD TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS ISSUED IN THE INQUEST OF MR ALAN DAVIES.

Thank you for providing the Health Board with an opportunity to respond to your concerns raised at the conclusion of the inquest of Mr Alan Davies.

At the outset I would wish to send my condolences on behalf of Swansea Bay University Health Board to Mr Davies's family.

In your Regulation 28 Prevention of Further Death notification you identified the following concerns and stated that it was your opinion there is a risk that future deaths will occur unless action is taken. Swansea Bay University Health Board sets out below the Coroner concerns and action taken which is within the power of the Health Board.

CONCERNS

1. There was limited communication between the Caswell clinic and HMP Cardiff following the s 117 meeting until Mr Davies' discharge. In particular, information that Mr Davies had commenced food refusal following the s 117 meeting and that it had not been possible to assess him physically prior to transfer was not clearly communicated to HMP Cardiff before the transfer occurred.

Swansea Bay University Health Board Response

There were two S.117 meetings in Mr Davies' case, Primary Care and Prison Mental Health Healthcare staff did not attend both meetings. Swansea University Health Board now request at S.117 meeting that Primary and Secondary MHIR Healthcare staff are requested to attend S.117. This ensures that both Physical and Mental Health needs are considered, discussed and plans agreed. Although a number of emails with information was sent, due to absences by staff this delayed the receipt of key information at the prison. In recognition Swansea Bay University Health Board have now obtained a central email address for HMP Cardiff and have also reached out to all other Welsh Prison Healthcare Teams to obtain the same, so that any further information needed can be easily shared.

To provide further structure to the S. 117 meetings to ensure all needs are addressed and discussed there is an updated S. 117 planning meeting document which is now being implemented in line with the 'Transfer and Remission of Prisoners Under the Mental Health Act 1983 – Good Practice Guidance 2021'. This template is attached **(Appendix 1)** and the subheadings in this template document provide a prompt to ensure all information relevant to a patient transfer is considered at the meeting. This has been shared via the Divisional governance structure – Quality & Safety and it is also being reiterated / disseminated via email and will be incorporated into the policy review.

At the time of Mr Davies transfer, it was not practice to ensure all relevant reports were shared from the multi-disciplinary team within Caswell but this has now changed and all such reports will be shared at / or in advance of the S.117 meeting.

This provides those attending the meeting with an opportunity to ask any relevant questions and to share appropriately those reports internally as needed ahead of the individual's actual transfer. This has been communicated to all staff via email.

The completed record of the S.117 meeting will be circulated to all those present (and to the central Prison Health Care email address for completeness).

The planning delays encountered between the date of the S. 117 meetings and the date of Mr Davies' transfer to HMP Cardiff due to additional Covid measures in place are no longer in existence and this means that the risk of information being superseded by events or changes is reduced although not eliminated and additional measures are covered below.

The Serious Incident Review recognised that although a number of reports were handed over to the Prison Mental Health Team prior to Mr Davies' transfer (email 1st September 2021) it would assist those receiving the individual to have one composite document with sufficient detail of the key information as a reference and as confirmed by the evidence of Stephen Jones, an updated Discharge Summary Template has been introduced (attached **Appendix 2**).

The Discharge Summary will contain both Physical and Mental Health details and will physically transfer with the patient / prisoner (even if transferred via an external agency) as part of the discharge pack. An entry outlining who handed it over to whom, on what date and what time must be entered into the patient's clinical notes.

In addition the pack must be electronically sent to the identified email inbox on the same day as the patient is transferred. A copy of the email will be saved in the electronic patient file. This will include the following: Care & Treatment Plan, Positive Behaviour Support grab sheets, Occupational Therapy report, Psychology report, Social Worker report and summary of the General Practitioner input. This has already been implemented and has been communicated across Caswell Clinic to all Consultants and Heads of Departments – this will also be included in the Policy review update.

The physical handover of the Discharge Summary means that the staff (which includes both Prison and Healthcare) at the Prison receiving the individual will have key information to hand at the point of the patient's admission into Prison. Therefore any changes between the S.117 meeting and discharge will be available in an easy up to date format at the time of discharge.

In addition, there is a verbal handover at the point of transfer. Caswell Clinic staff sometimes accompany the patient on transfer, but to ensure that key information accompanies the individual a verbal handover of information is given to external transport staff and this is now documented within

the clinical notes as noted above in order that a full handover occurs upon transfer. This has been communicated to remind staff.

Where patients are transferred from the Caswell Clinic back to Prison by an external company, the completed transfer report is saved on the patient's clinical file.

2. Discharge information and assessment was not provided to HMP Cardiff in a clear and easily understandable format to manage the known risks associated with the transfer of Mr Davies to prison.

Swansea Bay University Health Board Response

The action and changes implemented by Swansea Bay University Health Board to address this concern are set out in detail under point 1.

3. Mr Davies was transferred to prison without being accompanied by a member of Caswell Clinic staff. Agency staff did not have sufficient information to be able to assist prison reception staff in an informed way.

Swansea Bay University Health Board Response

As detailed above the physical handover of the detailed Discharge Summary upon transfer means all staff (which includes both Prison and Healthcare) at the Prison receiving the individual will have key information at the point of the patient's admission into Prison whether transported by staff from the Caswell Clinic or by an external agency. Information handed over to external transport is now documented within the clinical notes as noted above in order that a full handover occurs upon transfer.

Where patients are transferred from the Caswell Clinic back to Prison by an external company, the completed transfer report is now saved on the patient's clinical file.

4. Discharge information and assessment was not provided to HMP Cardiff in a clear and easily understandable format to manage the known risks associated with the transfer of Mr Davies to prison.

Swansea Bay University Health Board Response

As detailed under point 1 the revised Discharge Summary (Appendix 2) ensures that discharge information is provided in a clear and easily understandable format.

Feedback following the introduction of the new discharge summary has not yet been generated as the service has not remitted another patient to prison in the intervening period. However, there has been positive feedback when it has been used for discharges and transfers of patients to other services / supported community living for example.

5. Insufficient consideration was given to whether Mr Davies' needs were too complex to be met by HMP Cardiff.

Swansea Bay University Health Board Response

Where an individual is being discharged from a hospital environment it is the purpose of the S. 117 meeting to consider the most appropriate Prison environment to meet their needs. By way of reassurance of matters within the Health Board's power, as the Discharge Planning process now contains the sharing of more key information ahead of the S. 117, those in attendance can have an effective discussion on whether or not the proposed prison establishment is appropriate to meet the needs of any individual ahead of the transfer.

If during the S. 117 meeting it is established, when going through the domains of the prisoners care and treatment, that the identified prison does not have the facilities to meet the individual needs this will be highlighted and further exploration undertaken with the prison management in conjunction with the Ministry of Justice to source an alternative prison.

6. Mr Davies was transferred to HMP Cardiff with the intention that he be transferred again within a short time to HMP Parc. Insufficient consideration was given as to whether Mr Davies' needs were better met at an alternative specialist institution.

Swansea Bay University Health Board Response

This is not a matter within Swansea Bay University Health Board's power to influence, but by way of reassurance, we will ensure that the improved discharge planning process acts as an enabler to assist those making these decisions have the relevant clinical needs information to consider appropriateness of the given establishment.

7. No clear plan to promote Mr Davies' engagement with prison medical services, or the assessment of his mental or physical condition was devised or implemented at HMP Cardiff.

Swansea Bay University Health Board Response

Swansea Bay University Health Board does not have power to take action regarding the concern detailed.

8. No clear plan for the assessment of Mr Davies' capacity to refuse food or fluid was devised or implemented at HMP Cardiff.

Swansea Bay University Health Board Response

Swansea Bay University Health Board does not have power to take action regarding the concern detailed.

9. No food and fluid refusal policy was in place to guide healthcare staff.

Swansea Bay University Health Board Response

Swansea Bay University Health Board does not have power to take action regarding the concern detailed as we understand this concern relates to the period after transfer to HMP Cardiff. If not please could the Coroner advise and Swansea Bay University Health Board will consider any concern raised and address the same.

10. The number of GPs working in HMP Cardiff was insufficient to meet the demands upon them.

Swansea Bay University Health Board Response

Swansea Bay University Health Board does not have power to take action regarding the concern detailed.

11. The Nurse and Healthcare Assistant responsible for Mr Davies on the night of his collapse were working an 11.5 hour night shift without rest breaks, which they identified as being overly fatiguing.

Swansea Bay University Health Board Response

Swansea Bay University Health Board does not have power to take action regarding the concern detailed.

12. The Nurse, Healthcare Assistant and Custodial manager responsible for Mr Davies on the night of his collapse were not provided with clear information regarding the duration of his fluid and food refusal or the warning signs to consider in the context of the known risk of sudden collapse.

Swansea Bay University Health Board Response

Swansea Bay University Health Board does not have power to take action regarding the concern detailed.

13. The Health care assistant caring for Mr Davies overnight overheard more senior prison staff stating that they would not return to assist Mr Davies in healthcare, and felt unable to challenge this.

Swansea Bay University Health Board Response

Swansea Bay University Health Board does not have power to take action regarding the concern detailed.

Summary

I believe that the Health Board has taken such action within their power to address the concerns set out but by way of further reassurance - having reviewed some of the recent discharges, including prison transfers and the service is satisfied there is evidence of more robust S. 117 meetings and minutes prepared, with the distribution of Care and Treatment Plans, Positive Behavior Support grab sheets and other Multi-Disciplinary Team input including GP and primary health information shared at the S. 117 meeting. From the review there was evidenced that there had been circulation along with the minutes of the S. 117 meeting, to the nominated email addresses of the receiving service on the day or just prior to the transfer.

There is also evidence of an improvement in the information shared via electronic discharge / transfer of care system. The DALs (replacing EToC) provides a robust online template for all

healthcare professionals involved in the discharge or transfer of patient care to populate. It is compulsory for doctors to input all of the required information including Medicines E-Prescribing and Electronic Discharge Letters. These electronic systems were implemented across our Mental Health Services in July 2023, which involved the discontinuation of paper drug charts and any handwritten discharge letters, replaced by electronic drug prescribing and administration, and electronic discharge advice letters. The benefits of this electronic systems are:

- The ability to choose who to send discharge medication information at the point of discharge.
- A reduction of clinical incidents reported due to poor discharge information.
- A reduction of queries made by GPs due to poor discharge information.
- Discharge information can be sent to GPs, Pharmacies other health care staff within hours of discharge, compared to days or weeks in paper form.
- Clear and concise information regarding the patient stay, discharge medication, procedures and follow up plans.

I hope that you are assured from this response that the Health Board is taking appropriate measures within their power to address the issues that were identified during Mr Alan Davies's inquest.

Yours sincerely,

[redacted]

INTERIM CHIEF EXECUTIVE OFFICER

Enc – Statement of [redacted], Associate Nurse Director
Appendix 1 – S 117 Meeting Remission to Prison 2024 Template
Appendix 2 – Updated Discharge Summary Template