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

Bloc 5, Llys Carlton, Parc BusnesLlanelwy, Llanelwy, LL17 0JG

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

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

Dyddiad / Date: 31st July 2024

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Eric Thompson

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 14 June 2024, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Mr Eric Thompson.

I would like to begin by offering my deepest condolences to the family and friends of Mr Thompson, and to apologise on behalf of the Health Board for the concerns that you identified in Mr Thompson's care and treatment.

In the notice, you highlighted your concerns that there is no electronic method or system by which the laboratory can send results to the emergency department quickly and efficiently, with an alert to indicate abnormal results.

In response, our three hospital Medical Directors have reviewed the concerns you identified alongside colleagues in our Digital, Data and Technology Department. Our Deputy Executive Medical Director, who is a Consultant Emergency Medicine Physician, has also provided expert input into the discussions.

Our existing digital system, the Welsh Clinical Portal (WCP), which is used across various services, does notify a user that results are back for a particular patient once they log into the system, but it does not provide any further detail until the user goes into the individual patient details.

As you will know from our responses to other notices, the Health Board is committed to improved and integrated digital records and we will continue to work with national partners across Wales whom we rely upon to deliver this. The Health Board continues to do all it can on the issue of digital records, and the Board approved an outline business case for an All Age Mental Health Digital Solution at its meeting on 25 July 2024. This case will now be reviewed at the Welsh Government investment panel prior to a recommendation being made to the Cabinet Secretary for Health and Social Care. Whilst this of course would not be

relevant in Mr Thompson's case, I hope it shows to you the extensive work we are doing to seek the significant funding needed to move towards improved digital records.

In specific relation to the issue of abnormal results being communicated to the emergency department (ED) quickly, our Medical Directors have discussed this with senior clinicians and they have identified the telephone alert process is standard in most EDs. This method of alert is more likely to bring the abnormal result to the attention of the department than an IT related alert, due to the dynamic nature of the ED and the fact that most clinicians will be working agile and with patients rather than by a computer. Therefore, the arrangement of phone alerts would still have a valuable role in safety and is not likely to be replaced by any future electronic system (although we acknowledge such systems may provide improved access to information).

We do however fully recognise that on this occasion the process failed. You, and the family and friends of Mr Thompson, will therefore rightly want assurance that we will learn and improve our processes in order to do all we can to prevent a recurrence.

To that end, our three hospital Medical Directors will work with all of our three ED teams to review, revise and update the processes in place to ensure there is a clear mechanism for telephone alerts to be received and acted upon. That work will include ensuring the learning from this case is cascaded, that procedures are considered and updated, and importantly that staff are aware of those procedures.

We will seek evidence from each of the three hospitals that this work has been undertaken – and we expect that work to be undertaken and evidence provided by the end of September 2024 at the very latest (which recognises the summer pressures that our services face).

I hope this letter sets out for you the actions that we are taking to address the concerns you raised.

We would be happy to meet with you 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 Thompson for their loss.

Yours sincerely

[redacted]

[redacted]
Cyfarwyddwr Gweithredol Nyrsio a Bydwreigiaeth /
Executive Director of Nursing and Midwifery

cc [redacted]