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

John Gittins
HM Senior Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin LL15 1YN

Ein cyf / Our ref:
Eichcyf / Your ref:
☎: [redacted]
Gofynnwch am / Ask for: [redacted]
E-bost / Email: [redacted]
Dyddiad / Date: 09 September 2024

Dear Mr Gittins,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Paul Anthony Roberts

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 18 July 2024, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Mr Paul Roberts.

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

In the notice, you highlighted your concerns that:

1) there does not appear to be any consequences for staff members whose actions or omissions result in a failure to adhere to the policies and procedures which the Health Board impose for the safe care and treatment of patients; and
2) that the failure to act in a timely manner when learning and actions have been identified leads to a failure to mitigate the risk to patients.

In response to the Notice, I requested our Mental Health and Learning Disabilities Division (MHLD) and Central Integrated Health Community (Central IHC) to consider your concerns and provide details of their plans to make our services as safe as possible, taking into account the learning from the inquest.

Firstly, I would like to say that with the launch and implementation of the new Integrated Concerns Policy for the Health Board at the start of September 2024, we are rolling out a new approach to investigations.

The new policy provides a clear and straightforward framework for all staff, detailing the expectations of the Health Board for reporting, investigating and learning from incidents, mortality and complaints.

The policy was developed following extensive engagement and took into account the findings of our Learning from Investigations Project. As you know, we undertook a

retrospective review of 262 investigations. Significant learning was identified on how the Health Board approached its investigations which aligned with your own observations and that of Ms Robertson, Senior Coroner for North West Wales. The Chief Executive therefore commissioned a further programme of work to develop this new Integrated Policy covering Incidents, Complaints and Mortality Reviews. As Executive Director of Nursing and Midwifery, I oversaw this work along with the Acting Executive Director of Therapies and Health Sciences. The new policy was approved at the Board meeting in July 2024 and as mentioned above was implemented on 01 September 2024.

As part of the new policy, there is new guidance, training and templates. The new template includes clear guidance for the investigator that directs them to include staff immediately involved in the care and treatment. This will ensure that staff delivering care are active contributors to learning investigations moving forward; it will also prompt the escalation of concerns about care and treatment to the managers of staff to ensure that any actions or omissions are addressed with staff appropriately. This template will be in use from 15 September 2024 as part of the new policy implementation.

In addition to this, new training for investigating officers is being developed by the Health Board. The learning from Mr Roberts' inquest will be incorporated into this training, ensuring that investigators are aware of their responsibility to escalate concerns in relation to action or omissions in care and treatment to the managers of staff. This will then prompt consideration of professional and workforce processes. This training is scheduled to be launched at the end of October 2024.

The Health Board does have workforce policies that identify the action required in relation to staff whose practice falls below that of the standard expected. The Health Board strives to deal with capability issues in a fair and consistent manner, where the emphasis will not be punitive, but will help employees to undertake their work to the required standard through training and support. However, there are disciplinary processes that are enacted where needed.

With regard to your concerns about the failure to implement improvement actions in a timely manner, I can assure you that the outstanding Patient Information Leaflet is now in place within the Ysbyty Glan Clwyd Emergency Department and is given to patients at the point of triage. Adaptations are currently being made to launch the patient leaflet in both Ysbyty Wrexham Maelor and Ysbyty Gwynedd Emergency Departments. Completion of this will be monitored via the MHLD Learning and Action Group with an expected completion date of 25th September 2024.

The MHLD Learning and Action Group is responsible for the dissemination of learning attained via multiple routes such as investigations, inspections, inquests and mortality reviews. Moving forward this group will review the progression of open action plans and provide timely escalation to facilitate completion.

As part of the new policy, there are clear accountabilities now set on divisions to deliver the improvement and action plans. The Patient Safety Team, Complaints Team and

Clinical Effectiveness Team will conduct rolling audits of the Datix system to ensure divisions are uploading their Learning and Improvement Plans to Datix, that actions are being managed within date, and that evidence is being uploaded to support closure. This information will be used as part of governance and accountability processes and meetings to ensure the Health Board is delivering on its improvement commitments.

Later this year, we will also be launching a new Digital Learning Portal which is being designed to capture and cascade learning. Once this is launched, divisions will be responsible for ensuring information is entered into this system to enable learning to be recorded and cascaded across the organisation. This development is the first of a kind in Wales and is currently being actively developed by our IT department.

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

I would be happy to meet with you and discuss our work to improve patient safety 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 Roberts for their loss.

Yours sincerely

[redacted]

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

cc [redacted] Executive Director of Therapies and Health Sciences / Executive Lead for Mental Health
[redacted] Deputy Director of Quality