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

Ein cyf / Our ref: [redacted]
Eichcyf / Your ref:
☎: [redacted]
Gofynnwch am / Ask for: [redacted]
E-bost / Email: [redacted]
Dyddiad / Date: 13 May 2025

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Leanne Marie Carroll

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 19th March 2025, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Ms Leanne Marie Carroll.

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

In the notice, you highlighted your concern that at no time had any health professional referred Ms Carroll to the Perinatal Mental Health Service.

In response to the Notice, I requested our Mental Health and Learning Disabilities Division (MH&LD) 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 update you on the plans to raise awareness of the Perinatal Mental Health Service across the Health Board to ensure that mothers-to-be, and mothers who require assistance, are fully supported by the appropriate services.

Currently, mandatory perinatal mental health training is delivered to midwifery colleagues, student health visitors, obstetricians and gynaecologists, Community Mental Health Teams (CMHT's) and Home Treatment Teams (HTT). As extended members of the team, specialist perinatal health visitors provide training relating to the "Ask, Assess and Act Assessment Framework" whilst promoting the role of the Perinatal Mental Health Service. In addition, Institute of Health Visiting perinatal training is offered six times per year to the Health Visiting Teams, and members of the Mental Health Perinatal Team have undertaken train the trainer modules to disseminate this training further across the Health Board.

Moving forwards, the long-term plan is to integrate perinatal mental health training across the whole of the mental health acute care pathway to include in-patient services in addition to HTT, Psychiatric Liaison, and CMHTs. This is being processed through the Mental Health and Learning Disabilities Training and Development Group and it is expected that the perinatal awareness training will be fully ratified at the end of July 2025.

Alongside this, the Health Board's Perinatal Consultant Psychiatrist, [redacted], is leading on the development of training for GPs across North Wales. This training intends to increase knowledge of perinatal mental illness and the role and referral process for access to perinatal mental health assessment and support. [redacted] is in the process of liaising with GP colleagues with the aim of having initial training dates agreed by the beginning of September 2025.

With regard to Perinatal Health Visitors and the equity of access across North Wales, I can confirm that a review of Health Visiting Services across the Health Board that relate to wider perinatal services will be undertaken to determine whether gaps in service are evident. This will include consideration of access to specialist Perinatal Mental Health Services and the Mental Health Perinatal Service Manager will be involved within this process. An action plan will be developed to address any identified areas of need in order to ensure that there is equitable and appropriate access to perinatal services. Consideration will be given to the role and function of the Perinatal Health Visitor posts currently in place in the central and west areas on a temporary basis. This review will be undertaken with recommendations for the Health Board to consider by the end of July 2025.

I would like to take this opportunity to provide you with an overview of how referrals to the Perinatal Mental Health Service are managed. These referrals are reviewed via the daily Perinatal Referrals Meeting. This meeting, like the Single Point of Access and Assessment meetings (SPOAAs) across the rest of the division, reviews each perinatal referral entering the system. The meeting is structured to meet the Royal College of Psychiatrist: Standards for Community Perinatal Mental Health Services (6th Edition). The requirement is that all referrals are reviewed within 24 hours of receipt and the screening discussion and outcome communicated to the referrer within a further 24 hours. There is a draft Standard Operating Procedure for perinatal services and this is progressing through Health Board governance process prior to final ratification and implementation.

Within your notice, you raised your concern about the SPOAA meetings, in particular the records of meetings and the documentation of decisions made within the meeting. I would first like to provide you with an overview of the multi-disciplinary core membership of SPOAA meetings to demonstrate that the decisions are made by highly skilled and experienced clinicians. The core membership includes the Team Manager, Consultant Psychiatrist, Primary Care Practitioner, County Duty Practitioner and Older Persons Practitioner. In addition to those core members, attendance includes a Co-occurring Practitioner, Psychology, Therapies and Local Authority representation.

There is dedicated administration for the meetings to ensure that the referrals are collated, and a Clinical System Review is undertaken to determine any previous contact with mental health services and to document the outcome of discussions and action required, that both the referral documentation and the SPOAA spreadsheet are updated. The updated referral

document is filed within the patient's records. For any downgraded referrals (urgent to routine), a communication or direct contact to the referring clinician/service is required to provide an opportunity for further discussion if required. These actions are underpinned by the Interim Standing Operating Procedure for the Delivery of the Mental Health Measure (Wales) function in the Community Mental Health Services for adults in North Wales.

As an outcome of the inquest and subsequent notice, we have identified that consistency across the whole division is required in terms of the documentation used to record the summary and outcome of SPOAA Meetings.

The Community Transformation Meeting taking place on the 21st May 2025 is reviewing the Interim Standing Operating Procedure mentioned above and specifically Appendix 1 (the "SPOAA Referral Checklist") which is the agreed document that is filed within the patient records summarising the discussion at SPOAA and decisions/actions. The outcome of the meeting on the 21st May 2025 will be implementation of Appendix 1 across the division for all SPOAA Meetings from the 26th May 2025.

The Community Transformation Meeting will review the existing Mental Health Measure audit that currently takes place, which includes SPOAA records, to ensure that the audit template and frequency is consistent across the division.

With regard to staffing, I am able to confirm that the east Local Primary Mental Health Service is fully staffed and compliant with Part 1A and 1B of the Mental Health Measure.

I hope this letter sets out for you the actions we have taken to ensure the concerns raised by yourself are being addressed and mitigated.

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 Ms Carroll for their loss.

Yours sincerely

[redacted]

[redacted]
Cyfarwyddwr Gweithredol Gweithwyr Proffesiynol Perthynol i Iechyd a Gwyddor Iechyd
Executive Director of Allied Health Professionals and Health Science

cc [redacted], Deputy Director for Legal Services