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AW/KJF/INQ 9th November 2017 01443 744800 01443 744889

Patient Care & Safety

Private & Confidential

Mr Andrew Barkley Her Majesty's Coroner Coroner's Court Rock Grounds Aberdare CF44 7AE

Dear Mr Barkley

Re: Regulation 28 Report - David Michael Sewell

Further the Regulation 28 Report received on the 7th September 2017 with regards to the above may I present our response to the matters raised.

The Mental Health Directorate Management Team have reviewed the case and the circumstances of Mr Sewell's engagement. As you state a referral was received at the Community Mental health Team (CMHT) following assessment by the Psychiatric Liaison Service. The referral was sent to the CMHT following a detailed assessment on the 4th August 2017 that included consideration for detention under the Mental Health Act (MHA, 1983) which stated that Mr Sewell would not be detainable. It was therefore the professional view of the CMHT that this was not an option at the time of the presenting condition and that community services were deemed the appropriate course of action.

It is clear from the clinical records and the staff involved that the referral was received, and the case allocated, in a timely manner. The view of the CMHT was that the issue became one of engagement, exacerbated by the fact that the initial appointment resulted in confusion as to where Mr Sewell should attend.

This confusion arose as the CMHT had spoken with Mr Sewell and arranged for him to attend to meet with the allocated member of staff that would undertake the assessment at Ysbyty Cwm Cynon. This assessment would start the Care and Treatment Plan (CTP) process that would include the allocation of a Care Coordinator.

However Mr Sewell attended at the main reception in Ysbyty Cwm Cynon, instead of the reception in the Mental Health department. As he was not this et al. of the

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general systems for an appointment he subsequently left the hospital and was not seen. Further attempts to meet were met with hostility.

To reduce this potential for confusion in the future the Adult Mental Health Directorate management teams have written to colleagues who are responsible for staffing the main reception (and their managers). Within this letter it reminds staff that people arriving for appointments that are not on the main system should be asked if the appointment is with the Mental Heath Team and if so direct accordingly. Also to be alert to the fact that people may be confused on the matter and require more attention. (letter attached).

A review of the Disengagement Policy for Mental Health has been conducted, and it concluded that all stages of the policy were followed and it was reasonable at this time to discharge Mr Sewell as he clearly had no intention to meaningfully engage with the service. As consideration for Mental Health Act detention had been considered, the team wrote to Mr Sewell at the time as telephone contact was clearly antagonising the situation, to further offer a service.

On reflection the team felt that having had contact with the Crisis Service previously, any future difficulties experienced by Mr Sewell would have led him to contact these services either directly or through referral by his GP. Unfortunately his death 10 months later was not preceded with any such contact.

The Adult Mental Health Directorate have therefore concluded that it acted proportionately to the need presented at the time and in keeping with the Community Mental Health Act Disengagement Policy (enclosed). The possible requirement for using a MHA detention order was considered in Mr Sewell's assessment dated 4th August 2016. The Adult Mental Health Directorate also conclude that there was no further actions that we could have undertaken to engage with Mr Sewell, however, accept that procedures at the reception for engagement when discharged patients arrive unannounced or without an appointment require improvement.

Yours sincerely

Mrs Allison Williams
Chief Executive Officer

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