



GIG  
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WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

Heddfan AMHU,  
Ysbyty Maelor Wrecsam, Wrecsam,  
LL13 7TD

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Heddfan AMHU,  
Wrexham Maelor Hospital, Wrexham,  
LL13 7TD

Mr. John Gittins  
H M Coroner North Wales  
County Hall  
Wynnstay Road  
Ruthin  
Denbighshire  
LL16 1YN

Ein cyf / Our ref: INC125498 – INQ2821

Eich cyf / Your ref:

Ffôn / Telephone: 01745 586391

Gofynnwch am / Ask  
for: [REDACTED]

E-bost / Email: [REDACTED]

Dyddiad / Date: 2<sup>nd</sup> February 2018

Dear Mr Gittins

**Re: Regulation 28 Response re Mr. Daniel Watson**

I write in response to the Regulation 28 issued on 18<sup>th</sup> December 2017 as a result of the Inquest into the death of Mr. Daniel Watson.

In relation to your first matter of concern in that the Concerns Root Cause Analysis Investigation undertaken by BCUHB revealed a multitude of care and delivery problems which cumulatively represented missed opportunities to improve the Deceased's mental health. As you are aware an action plan has been produced to improve on the service delivery and this has been provided to you. In relation to evidence given at the Inquest by the Community Psychiatric Nurse (CPN), I can confirm that the CPN was provided with an initial debriefing session to reflect on the delivery of evidence provided at the Inquest. Further debriefing and ongoing supervision will provide the opportunity for the CPN to optimise learning and provide a focus on their understanding and empathy for their continued professional development, which will be incorporated into their appraisal. An initial focused session for the wider team's learning will be held around awareness of empathy towards families and transparency to the Coroner at Inquest

In relation to your second area of concern relating to a significant improvement in the training of staff within the CMHT in relation to their understanding of risk assessment and potential escalation of concerns to a formal Psychiatric Assessment. The Wales Applied Risk Research Network (WARRN) Asking Difficult Questions and Formulating Risk (WARRN ADQ) is a National Programme of training, endorsed by Welsh Government, in the assessment, formulation and management of risk to self or others. One of the main aims of WARRN is to drive forward a standardised and consistent approach to risk assessment and formulation nationally, across services. The MHLD Division will continue to make available the WARRN Accredited Programme for Care Coordinators and new training dates have been confirmed for 2018 to be delivered through our group of specialised trainers. A copy of the training dates is attached. I can also confirm the CPN has previously received WARRN training in 2012.



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I can also confirm that the MHL Division will have updated the MHL Supervision Guidance for Nurses and Support Workers Policy by the end of February 2018 to ensure staff can discuss and reflect on cases in a structured and facilitated process. A copy of the draft MHL Supervision Guidance for Nurses and Support Workers Policy is attached.

Assurance regarding compliance with appraisals and training is provided to the Senior Management Team on a monthly basis through the network teams performance report. Additionally, the MHL Division has committed to undertaking a bi annual audit of Care and Treatment Plans using the Welsh Government recommended audit tool (see attached) which will be reviewed biannually within the divisions Quality and Safety Group and reported within our annual report on the local delivery of '*Together for Mental Health*'.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Andy Roach'.

**Andy Roach**  
**Cyfarwyddwr Iechyd Meddwl ag Anabledd Dysgu**  
**Director of Mental Health and Learning Disabilities**