GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Eich cyf/Your ref:
Ein cyf/Our ref: LR-jb-02-7284
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Len Richards
Chief Executive

12 February 2019

Miss R Knight
Assistant Coroner
Coroner's office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

Dear Miss Knight

Ruth Ellen Edwards (deceased) D.O.D. 31/08/2018

Thank you for your letter of 20 December 2018, in which you outline your concerns regarding the death of Mrs Ruth Edwards, and issue a Regulation 28 order detailing the areas you wish the University Health Board to consider.

We recognise that this will have been a very difficult time for Mrs Edwards's family and would like to offer our most sincere condolences. The University Health Board has conducted an internal review of the processes (known as the Multi-Disciplinary Case Review or MCR) involved in the care and treatment offered to Mrs Edwards following her presentation at the University Hospital of Wales (Accident and Emergency). Unfortunately no member of UHB staff who were involved in dealing with Mrs Edwards were called to give evidence at the Inquest and it may have been possible to provide some further assurance in relation to the areas of concern that have been highlighted.

Your concerns with regards to her care are as follows:

That Mrs Edwards was discharged from hospital following an overdose on 23rd August to see GP was surprising. It was expected in these circumstances that Mrs Edwards would have been transferred to Llandough Hospital for a psychiatric liaison assessment instead; responsibility for any further assessment and treatment of Mrs Edwards was passed entirely to Mrs Edwards and her family.

A less capable family/individual may not have pursued help and fallen through the cracks. Furthermore had Mrs Edwards been hospitalised, her treatment may have been different.

The findings of our internal MCR concluded that the care and treatment given to Mrs Edwards from the point of the mental health assessment conducted by the REACT team the following day, was comprehensive and demonstrated full awareness of Mrs Edwards's history, her level of risk, the true nature of her overdose the previous day and balanced this against the capability of Mrs Edwards's family to provide a safe and supportive context.

The UHB would absolutely concur that some families may not have been in a position to provide ongoing support, but the judgement that Mrs Edwards might remain at home with regular and frequent input from the REACT team was made with the conscious participation and agreement of all, including the team, the patient and the family.

It is clear from the accounts given by all professionals involved that consideration was given almost on a daily basis to whether Mrs Edwards should be admitted to a hospital bed. It is equally clear that this was consciously balanced against the possibility that hospital admission may have been detrimental to Mrs Edwards. Mrs Edwards herself was not amenable to hospital admission. It is normal and good practice to provide treatment and support at home wherever possible, and it was concluded that the decision to do this was appropriate in this case, based on the information that was available to clinicians at the time.

The consultation at the UHW on 23 August was poor. The history taking was inadequate as it did not reveal the true extent of Mrs Edwards risk in terms of previous suicide attempts and deep seated mental health problems. Furthermore, inaccurate information was communicated to liaison psychiatry; they were told that Mrs Edwards had taken 2 tablets when she had taken 20.

Mrs Edwards had not had any involvement with mental health services for many years, and there was therefore no information available to the assessing doctor from either paper notes or the electronic PARIS mental health record system. [redacted] would therefore have been restricted to the information that Mrs Edwards (and those accompanying her) gave him at the time. Had Mrs Edwards's involvement with mental health been within the last several years, then a PARIS history would have been available to [redacted] and will be available for other patients presenting in similar circumstances.

Our review has identified that, although there was a typographical error in the documentation stating that only two tablets of Sertraline had been taken when in fact the true figure was twenty, this error was rectified on the night in question: when [redacted] had his discussion with Mark Bates (the night site coordinator for mental health services), both individuals knew that twenty tablets had been taken and made their clinical decision on that basis. This is borne out by the notes taken by [redacted] at the time, and also I can confirm that the night site coordinator in mental health services has located his own personal notes from that night, in which he has written that Mrs Edwards took twenty tablets, not two. The typographical error was therefore *not* a factor in the decision making process on that night.

Positive About Disabled People

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The GP practice may not have performed suitable frequent medication reviews with Mrs Edwards. Many boxes of different tablets were found at the family home. Many on repeat prescription posing an overdose risk.

This issue will be raised this with the Primary, Community and Intermediate Care Clinical Board as a practice issue for them to consider.

With regards to the specific issues you have asked the UHB to consider in order to prevent future deaths:

The identification of patients who require immediate psychiatric assessments and review by specialist teams.

The UHB uses the Bristol Matrix, a decision making tool which is used to support the identification of patients who require psychiatric assessments. This decision making can also be conducted jointly with senior mental health staff. I can confirm that training in the use of the Bristol Matrix is well established, that all junior doctors learn about it during their induction to the department and are familiar with its use which is standard practice in this kind of situation.

The doctor that conducted the initial assessment is a locum in the department but has many years' experience in emergency medicine and works regularly in the department. She has had training in the assessment of the patient with mental health problems and would have felt confident in entrusting a decision that the patient was low risk and safe for out- patient review.

The care and attention to detail taken by doctors and other healthcare professionals when nothing histories and information from mental health patients.

Although the internal MCR has identified a typographical error as described above the general standard of documentation was found to be satisfactory. All staff will, however, be reminded of the importance of full and diligent information taking, using all information that is available at the time and this will be achieved through the Clinical Board's Quality, Safety and Experience structures.

The frequency of medication reviews with mental health patients

Mrs Edwards was not known to secondary care mental health services at the time of her death. Her care was being provided by her General Practitioner. The management of patients with Depression is carried out in line with NICE Guidance 'CG90 – Depression in adults: recognition and management' and there is a standard for the regular review of patients depending on the nature and severity of their depression. This matter has been raised with the Primary Community and Intermediate Care Clinical Board as a practice issue for them to consider.

POSITIVE ABOUT DISABLED PEOPLE

I hope that the information set out in this letter provides you with the assurance that the Health Board has fully considered the issues raised as a consequence of the inquest into Mrs Edwards's death, and has taken appropriate action in response.

Yours sincerely

Len Richards
Chief Executive