[redacted] Cadeirydd / Chair
Ffon / Phone: [redacted]
E-bost / Email: [redacted]

Carol Shillabeer, Y Prif Weithredwr / Chief Executive
Ffon / Phone: [redacted]
E-bost / Email: [redacted]

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

2 September 2019

Our Ref: WM/RM/147
Your Ref: 15662

Mr I Boyes
HM Assistant Coroner
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF371 JW

RECEIVED
10 SEP 2019

Dear Mr Boyes

Regulation 28 Report reference Barbara Humphreys (deceased)

I write in response to receipt of the Regulation 28 report in respect of the above named.

The health board became aware of this sad incident through our care home governance monitoring processes. On behalf of the health board I extend sincere condolences to Mrs Humphries' family.

In response to the matters of concern, I have detailed below the actions taken by the health board to put improvements in place to improve the care and treatment provided and to ensure lessons are learnt and shared. We are further sighted on the actions led through the Adult Protection General Protection Plan overseen by Powys County Council as part of our care home governance arrangements, which we take account of through our commissioning assurance framework. The latter seeks to provide assurance on the quality, safety and experience of care and treatment provided for residents who access the care homes.

Assurance has been provided to the health board on the actions that have taken place in response to the Adult Protection General Protection Plan which addresses matters 1-5 of the Regulation 28 report. The health board has also received confirmation that the MHRA: Safe use of bed rails (December 2013) guidance was circulated to all Care Home Providers in February 2019 for their

reference as part of the wider sharing of lessons. Through our care home governance framework, the health board will continue to monitor the standards of care and treatment provided to Powys residents. A planned date for a joint monitoring visit with Powys County Council was in place but was subsequently postponed whilst the regular visits from the Health and Safety Executive and Care Inspectorate Wales took place. Importantly, a new date is currently being agreed for the visit which will be unannounced. The team that undertakes review visits has also been strengthened with a new addition to the team representing pharmacy and medicines management.

With reference to point 6 and 7 of your report, [redacted] Medical Director, Powys Teaching Health Board has reviewed the Regulation 28 report and progressed the following actions:

[redacted] has taken account of the General Practitioner's (GP) standard of behaviour, professional practice and record keeping standards. The latter is particularly important where impairment of capacity is present, as in this case, and the need to ensure the family/next of kin are informed of both a doctor's attendance and their management plans. He has highlighted the importance of keeping accurate records as a doctor, a requirement within the General Medical Council's (GMC) 'Good Medical Practice' https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice (paras 19-21).

In reference to 'do not attempt cardiopulmonary resuscitation (DNACPR)' orders, Mr Parry has highlighted the considerations here in relation to the doctor's role. The doctor needs to be aware (if they are not already) of the GMC guidance https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life on both lack of mental capacity (paras 15 and 16) and DNACPR (paras 129-136). Both sections highlight the need for discussion with carers/family members and related care givers and the need to be clear on the process for and justification of, any decisions that are made about the individual patient. Although it is suggested a policy is constructed around these, it is in fact the case that this already exists insofar as it would relate to doctors in this scenario, and this is within the referenced GMC guidance above.

I can confirm Mr Parry is writing to the General Practitioner concerned with the intention of outlining the following:

1. The importance of clarity and transparency in their interactions with Crossfield and other institutions for which they provide medical services. This transparency would include attending within a reasonable time scale when requested and making their presence known to the facility when they do attend.
2. The GP's responsibilities when reviewing patients as requested to do so and making properly documented contemporaneous written (or electronic as appropriate) records of their attendance, findings and management plan.
3. Ensure that discussions are undertaken with the patient/ family/ care givers that not only acknowledge the patient/ family/ care givers views

but also make plain the management plans being proposed. These discussions, and their agreed outcomes, must be documented in the patient record.

4. That where issues of DNACPR appear to arise then discussions with the patient (where capacity exists), family and care givers as to the appropriateness of this are undertaken, agreed and documented in the patient record.

[redacted] has further confirmed his intention to make the GP aware of the relevant GMC guidance referenced above and will request that this case is discussed as an untoward event within the doctor's annual appraisal if it has not been already. Additionally, it is important that the doctor reflects adequately on the case, the guidance and the outcomes for them as a result.

I can further confirm with regards point 7, all residents without capacity should have Deprivation of Liberty Safeguards (DOLs) in place for use of bed rails. In order to complete the DOLs a Best Interest decision is completed. This will be reviewed and monitored as part of the planned announced joint monitoring visit within the care home governance framework.

I hope this response provides you with assurance that we have addressed the actions cited in the said Regulation 28 report.

Yours sincerely

Carol Shillabeer
Chief Executive