GIG NHS | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our ref: [redacted] Direct Line [redacted] 4 February 2021

Ms Caroline Saunders
HM Senior Coroner for Gwent
Room 204W
The Civic Centre
Godfrey Road
Newport
NP20 4UR

Dear Ms Saunders

Re: Regulation 28 Report received by Aneurin Bevan University Health Board further to the inquest touching on the death of Rory Attwood.

Thank you for your report dated 10 December 2020, which was received by the Health Board on 15 December 2020.

Further to your report, I am pleased to inform you that the Aneurin Bevan University Health Board has reviewed its practices with regard to GP involvement in Serious Incident Reviews.

Furthermore, the Mental Health and Learning Disabilities Division has devised a process and pro forma to aid the timely sharing of pertinent information, and to ensure that GPs are routinely invited to participate in reviews of Serious Incidents. Copies of both documents are enclosed for your information. Whilst I must highlight that only a small number of GP Surgeries within the Gwent area are managed by the Health Board and the vast majority are managed independently, it is hoped that this process will enable the Health Board to engage with both managed and non-managed GP surgeries when conducting Serious Incident Reviews.

The Mental Health and Learning Disabilities Division is reviewing its processes to ensure that involvement of third sector and other organisations is recorded sooner, thus ensuring that such organisations are also invited to participate when they have been involved in a person's care. This invitation will be sent in letter format as opposed to the pro forma format described above.

Pencadlys
Ysbyty Sant Cadog
Ffordd Y Lodj
Caerllion
Casnewydd
De Cymru NP18 3XQ
Ffôn: 01633 234234

Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
South Wales NP18 3XQ
Tel No: 01633 234234

I trust that this information addresses the concerns raised in your report, however please do not hesitate to contact me should you require any further information.

Yours sincerely

[redacted]

Chief Executive/Prif Weithredwr

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MENTAL HEALTH & LEARNING DISABILITIES DIVISION

NOTIFICATION TO GP OF AN SUI REVIEW IN THE DIVISION

TO
Dr *GP address*
✆
✉

FROM
[redacted] Head of Quality & Improvement QPS Department, MH & LD Division Divisional Office St Cadoc's Hospital Lodge Road, Caerleon, Newport. NP18 3XQ
✆ [redacted]
✉

Dear Dr xxxxx

We have been notified recently of the death of a patient known to your practice. As an unexpected death, this meets the criteria for a Serious Untoward Incident within the Division and thus the Division will be reviewing this patient's care from the Mental Health/ Learning Disability service. I would be grateful if you would kindly return this form to the above email address at your earliest convenience, answering the following:

a) I attach pertinent information with regard to recent (last 6 months) Primary Care involvement — ☐ Tick to indicate attached

b) I would like to be included in the review of this patient's care — Yes ☐ No ☐

Many thanks

[redacted] Head of Quality & Improvement

INCIDENT REFERENCE NO.	[redacted]

DETAILS OF PERSON	
Name	
Date of Birth	
Address	

MH SERVICE INFORMATION	
Team	
Consultant (if applicable)	
Last Contact	

OVERVIEW OF THE INCIDENT	
Date and time of incident	
Location of incident	
Brief Summary of incident	
Suspected Cause of Death (If known)	

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MENTAL HEALTH & LEARNING DISABILITIES DIVISION

PROCESS FOR NOTIFYING AND INCLUDING GP IN SERIOUS UNTOWARD INCIDENT REVIEWS IN THE DIVISION

Situation

Following a recent Coroner's Inquest into the death of a man who had previously been known to the Mental Health service, HM Senior Coroner wrote the Health Board on 10 December 2020 enclosing a Regulation 28 report. HM Coroner asks the Health Board whether it intends *"to review the current process of serious incident investigation and ensure that General Practitioners (and indeed any other relevant third party agencies) are to be to be routinely involved in serious incident reviews in the future"*.

Background

Within the MH & LD Division, the following incidents will trigger notification to Welsh Government/ Delivery Unit

- Unexpected death or suspected suicide of any patient
  a) open to the secondary care mental health service
  b) open to the secondary care mental health service in the previous 12 months to include
    - Current in-patient (informal)
    - Current in-patient (detained)
    - Current patient of CRHTT
- Unexpected death within 14 days of discharge from MH ward
- 'Expected' deaths if the patient is detained to a MH ward
- Unexpected death or suspected suicide of any patient known to PCMHSS, GSSMS, Learning Disability Service or Secondary Care Mental Health Service within the last 12 months
- Suspected homicide perpetrated by a patient open to a secondary care MH service
- Any incident that staff or relatives identify as potentially having been contributed to by act or omission on behalf of the Health Board

For most incidents, a concise review is completed by the team, collating the details of the person and the incident, and providing a chronology of events. This is then reviewed by a group of senior clinical staff from within the Division and the wider Health Board (e.g. Safeguarding, Legal Services etc) and decision made as to whether a Reviewing Officer should be appointed to complete a comprehensive review.

Assessment

The Division does not currently routinely request information or involvement from GP unless the terms of reference for review include this and/or the GP has been very much involved in the care.

Where other agencies have been involved, such as the Local Authority Social Services and/or third sector/ independent providers, the Reviewing Officer would make contact with these organisations

Recommendations

1. The MH & LD Division will use a pro forma to notify the GP of an unexpected death of a patient in the Division. This will be sent by email from the Division's Quality and Patient Safety (QPS) department to the GP Practice.
2. The Pro Forma gives the patient details and a summary of the incident, and requests a brief copy of recent/ salient information from the GP. It also asks the GP to confirm whether they would like to be involved in the review.
3. The GP Practice then emails this pro forma back to the Division's QPS department.

It is suggested that this process is tried for 6 months; following which, the MH & LD Division will liaise with the Primary Care and Community Division to review the process and take forward any suggested amendments.

[redacted]
Head of Quality & Improvement
MH & LD Division
1.2.21

For review August 2021