GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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[redacted]

Mr John Gittins
Senior Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin
LL15 1YN

Dyddiad / Date: 11th January 2022

Dear Mr Gittins,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Kyle Nicholas James Hurst

I write in response to the Regulation 28 Report to Prevent of Future Deaths issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Kyle Hurst.

I would like to begin by offering my deepest condolences to the family and friends of Mr Hurst, and I apologise for the concerns identified at the inquest that have given rise to your notice.

The standard paracetamol antidote is N Acetylcysteine (NAC) given as an infusion. The standard NAC infusion regime is given over 21 hours. There is however mounting evidence that this can safely be given over a shorter period of time (12 hours) and this accelerated regime is known as the SNAP protocol. The regimes relate to the way the antidote is prescribed and given and the main benefit is of reduced length of stay with the SNAP regime, it does not however mean initiating the antidote any sooner.

Although there is evidence accumulating that the accelerated regime is safe, and it is being used by many UK hospitals now and it is referenced on TOXBASE guidance as an option, it is still not officially sanctioned by the MHRA (Medicines & Healthcare products Regulatory Authority). As such, any local adoption of the protocol requires each organisation to locally review and authorise such actions. Within the Health Board, this would be after careful local examination and consultation and formal approval at the Drugs and Therapeutics Group.

At inquest, our witnesses gave evidence that across the Health Board we were working to overhaul our paracetamol pathways and to include the SNAP protocol, and the SNAP protocol was still going through the process of gaining approval.

An updated protocol has been developed and was being formally approved at our Drugs and Therapeutics Group in January. However, due to the unexpected wave of COVID pressures arising from the Omicron variant and the redeployment of staff to vaccination and front line services, this meeting has been cancelled. We therefore intend to take executive decision to approve this procedure outside of the normal governance process and this will be completed no later than the 31 January 2022. Once approved, we will begin use of the protocol immediately.

In relation to the procedures to mitigate the risk of not acting upon diagnostic results, we have developed a new Procedure for the Communication of Critical and Unexpected Pathology Results. This document sets out the roles and responsibilities of staff and the process to follow. This new procedure has been ratified.

We have had to strike a balance between expediting the implementation of new procedures whilst ensuring proper governance, clinical engagement and the correct implementation of any changes. However I hope the actions we are taking to ensure special approval gives you confidence we will intervene where unacceptable delays occur.

I am concerned to have heard from you that the Health Board has not on a number of occasions met its own deadlines for improvement actions following serious incident investigations. Whilst the COVID pandemic has undoubtedly impacted us greatly, I accept this is not an acceptable position and we must improve.

In April 2021 we changed our serious incident process and this included all investigation reports going for scrutiny and approval at an Incident Learning Panel. This new step in the process adds an organisational level of scrutiny on all investigations completed by our clinical divisions and we have seen an improvement in the quality of reports and action plans as a result. We are also now tracking actions from these investigation reports through our Datix patient safety system and auditing compliance with action completion timeframes and evidence.

This process covers incidents from April 2021 onwards, and so for incidents prior to this we have appointed a clinician to undertake a review of historic action plans to ensure evidence is available against each action. This person commenced in post in November, however they have been redeployed to front line services as a result of the current COVID wave, and we hope they will be available to return back to this important work during January 2022.

I hope my letter offers you assurance that we have worked to address the concerns, and importantly that we have a new system in place to provide greater oversight and assurance in the future.

One again, please may I offer my condolences to the loved ones of Mr Hurst and my apologies for the concerns you have identified.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Should you require any further information or evidence of the actions outlined above please contact either myself or Matthew Joyes, Associate Director of Quality Assurance.

Yours sincerely

[redacted]

Prif Weithredwr
Chief Executive