GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

[redacted]

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

Pencadlys Bwrdd Iechyd Prifysgol Bae Abertawe Headquarters
Un Porthfa Talbot, Parc Ynni, Baglan, Port Talbot, SA12 7BR [redacted]

Swansea Bay University Health Board Headquarters
One Talbot Gateway, Baglan Energy Park, Port Talbot, SA12 7BR [redacted]
Rydym yn croesawu gohebiaeth yn y Gymraeg ac yn y Saesneg. We welcome correspondence in Welsh or English.

[redacted]

[redacted]

Date: 23rd November 2019

Dear Mr Gruffydd,

RE - Regulation 28 Response - Jane Livingston

I write further to your letter dated 4th October 2019, enclosing the Report to Prevent Future Deaths following the inquest held into the death of Jane Livingston on 30th September 2019 where the conclusion reached was suicide.

Thank you for providing us with an opportunity to review the issues that your report raises. I can confirm that a detailed review of the information in the report has been undertaken by the Quality and Safety team for the Mental Health Swansea locality at Swansea Bay University Health Board.

A full investigation has been conducted into the events of the 14th December and can be outlined below;

- The Community Mental Health Team (CMHT) conducted a Duty Assessment on Ms Livingston on 14th December 2018 and deemed that Ms Livingston required further assessment by the Assessment and Home Treatment Team (AHTT) at Cefn Coed Hospital.

  On completing the duty assessment, the CMHT staff documented the assessment on to the electronic social care system (PARIS).

  I understand that the Coroner's concerns were that this review had not been uploaded onto the electronic case management system before the AHTT gatekeeping

assessment. As such, this could create a situation where an assessment takes place based on incomplete previous information which presented a risk to patients.

The Health Board confirms that the PARIS system has been audited during our investigation, and can confirm that the CMHT staff accessed the system at 12.29hrs on the 14th December 2018 to document the duty assessment conducted on Ms Livingston. Please see appendix 1 for assessment.

Once the duty assessment had been documented, the CMHT staff contacted the AHTT team via telephone to arrange the AHTT Assessment (gateway assessment). The telephone call involved a verbal summary of the case including the risks identified, requesting an AHTT gateway assessment. The AHTT confirmed acceptance of Ms Livingston, and arranged a gateway assessment as an outcome of the telephone call. The enquiry was accepted and documented on the PARIS system at 14.13hrs (please see appendix 2).

The AHTT team completed their gateway assessment of Ms Livingston and accessed the PARIS system at 14.36hrs to document the visit. Please see appendix 3 for the case note entry of this visit and appendix 4 for the assessment.

The Investigation into this matter has identified that the entries made during the first duty assessment were available for the later gateway assessment. It also identified that the assessors in the gateway assessment were aware of Ms Livingston's wishes for hospital treatment. The information documented in the gateway assessment demonstrates the decision making process in respect of Ms Livingston wish to go to hospital, discussing and agreeing treatment options.

The duty assessment (appendix 1) was available to the AHTT gateway assessors at Cefn Coed but unfortunately did not form part of the Coroner's Inquest disclosure. The Health Board are extremely sorry for this disclosure omission.

Actions to ensure patient notes are available to inform subsequent assessment

- Confirmation that the process outlined above is the standard process for referring and arranging gateway assessments and sharing information between services effectively.

- Confirmation that the referral process is documented on the system via the enquiry function on the PARIS system.

- Confirmation that the PARIS system has the functionality to allow users to access and view the system in real time including when it is being edited by another user.

Action to ensure that Coroner has access to all patient records for inquest

- When requesting a copy of mental health notes, a specific request is now also made for all PARIS electronic records by the Corporate Legal Team.

- The Mental Health Quality and Safety team will identify all the possible locations of patient records across mental health Services, this information will be used to develop a checklist, which can be used to audit the completeness of records prior those records being disclosed to HMC Coroner. This will be completed by 21st December 2019.

I hope that the information provided within this response by the Mental Health and Learning Disabilities Delivery Unit has provided assurance to the HMC Coroner that the risks identified in the Regulation 28 report on the death of Jane Livingston are adequately explained, and that learning around disclosure going forward has been addressed.

Yours sincerely

[redacted]

[redacted] [redacted]
Chief Executive

Appendices

1. CMHT CPA assessment 14/12/2018	Appendix 1 - CMHT assessment 14.12.20
2. AHTT Enquiry 14/12/2018	Appendix 2- AHTT enquiry 14.12.2018.p
3. AHTT case note entry 14/12/2018	Appendix 3 - AHTT case note entry 14.1
4. AHTT CPA assessment 14/12/2018	Appendix 4 - AHTT CPA assessment 14.