Freedom of Information Request: Our Reference CTHB_266_17

You asked:

1. How many reports of regulation 28: report to prevent further deaths, were received between 1st January 2015 and 31st March 2017?
2. What matters of concern were highlighted?
3. What actions were taken in response to said reports?
4. Copies of all responses to said reports.

Our response:

1. The Health Board received 14 Regulation 28 Reports between the 1st January 2015 and the 31st March 2017.

2. As this information is routinely published, it is therefore exempt from disclosure under Section 21 (information accessible by other means). As this is an absolute exemption under the Freedom of Information Act 2000, there is no requirement for the Health Board to consider the public interest test. Details of these reports (concerns highlighted) can be found at https://www.judiciary.gov.uk/subject/hospital-death-clinical-procedures-and-medical-management-related-deaths/ .

3. On receipt of a regulation 28 report, an action plan is developed and implemented to address the failings identified. A summary of the learning and the actions implemented or being undertaken is provided below:
   - Formal escalation pathway for when adult critical care is at capacity in Wales
   - Development of a pathway for Percutaneous Coronary Intervention for the out of hospital cardiac arrest / unconscious patient
   - Evaluation of suspected ventriculoperitoneal Shunt malfunction guideline developed
   - Introduction of risk based assessment to determine if Percutaneous Tracheotomies should be performed in the Theatre setting
   - Review of the policy and guidelines for the insertion of Nasogastric Tubes
   - Review and updating of the INR monitoring and reporting process
   - Review of the Care Treatment Plan Policy and Procedures within Mental Health Outpatients
   - Improved communication between Hospital Wards and District Nursing Teams
   - Improved communication between District Nursing Team and GP Practice Nurses

- Strengthened referral process to the Tissue Viability Nursing Service for specialist advice and support
- Training provided in relation to the recording, escalation and responding of NEWS
- Patient Safety Alerts disseminated to remind staff of the importance of documenting a history of Falls and sedation

Trends identified via concerns and inquests inform improvement work undertaken within the Health Board through structured consideration at the Quality Steering Group and inclusion in the Quality Delivery Plan. This includes reducing healthcare acquired pressure ulcers, reducing patient falls resulting in harm, improving care for patients with dementia and recuing waiting times and improving patient flow. The Health Board has appointed Practice Educators who support the implementation of action plans and sharing of Learning across the Health Board. In addition they provided targeted training to areas where themes are identified.

4. In response to your request for copies of all reports I can confirm that the Health Board holds the information. However, whilst the letter to the Health Board is in the public domain, the responses to the Coroner are not routinely published. This is due to the fact that they can contain sensitive detailed action plans in relation to each individual case. The Health Board has considered its duty of confidentiality, which does continue after the death of an individual to whom that duty is owed; especially where after death, it can be enforced by the deceased's personal representative**.**

   We have considered approaching the individuals families for consent, however feel that this would not be appropriate to do so given the time frame related to some of these responses and the distress that could be caused from revisiting some incidents. We have therefore relied upon Section 40 (personal information) to withhold the individual reports at this time.