GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Mr Andrew Barkley
HM Coroner for Cardiff and the Vale of Glamorgan
Aberdare Police Station
Cross Street
Aberdare
CF44 7EG
01443 743698

01443 744800
[redacted]

2nd October 2014

Dear Mr Barkley,

Re: Regulation 28 Coroner's Rules
Vivian Herbert Hunt (died 4th April 2014)

I refer to your email correspondence sent on 6th August 2014, enclosing the Regulation 28 report, which details the areas of concern following your conclusion of the inquest on 6th August 2014 touching on the death of Mr Vivian Herbert Hunt on 4th April 2014.

Please be assured that the Health Board has taken this matter extremely seriously and has learnt lessons following investigation and the matters raised at the inquest into the circumstances. Robust action has been to taken to minimise the risk of any recurrence.

1. **Action taken to plan and monitor improvements**

   A corrective Action Plan for Improvement was developed to ensure effective action; this is attached.

2. **Actions implemented**

   I can confirm that the actions have been taken forward by the Mental Health Directorate with regards to compliance with neurological investigations post head injury; actions still in progress will be monitored through to completion by the Health Board's governance groups. The progress made by 29th September 2014 is reflected in the updated plan as attached.

I sincerely hope that this information and enclosed Action Plan will reassure you that the Health Board has learnt important lessons from the investigation into the care provided to Mr Hunt and that effective action has now been taken to prevent future deaths.

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I would like to convey once again my deepest sympathy and sincere apologies to Mr Hunt's family for the failings identified.

If you require any additional information or clarification please do not hesitate to contact me.

Yours sincerely [redacted]

Deputy CEO

pp **Mrs AJ Williams**

Chief Executive Officer
Cwm Taf University Health Board