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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Ysbyty Gwynedd, Penrhosgarnedd, Bangor,
Gwynedd, LL57 2PW

PRIVATE & CONFIDENTIAL

Mr J Gittins
H M Coroner North Wales
County Hall
Wynnstay Road
Ruthin, Denbighshire
LL15 1YN

EIn cyf / Our ref: INC59087

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Dyddiad / Date: 21st October 2016

Dear Mr Gittins

Re: Regulation 28 letter in respect of Pamela Conwy

Further to your Regulation 28 notifications to the Health Board following the inquest of Pamela Conwy.

The Health Board has considered your concerns in relation to the following issues outlined in the two notifications:

First Regulation 28 Notification

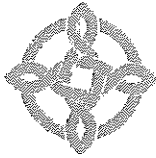
Part 1 – That notwithstanding changes which have been made by both BCUHB and WAST, there remain wholly unacceptable delays with patients being kept waiting for long periods in ambulances and ambulance resources consequences being unavailable for allocation to other calls as a result of which the risk of future deaths continues

Part 2 – Evidence at the inquest indicated that the problem of patient flow in the Maelor result in patient delays within the Emergency Department and it is of considerable concern to me that such problems have been the subject of previous regulation 28 reports and are also within the scope of a number of ongoing inquests

Second Regulation 28 Notification

Part 1 - Evidence at the inquest indicated that discussions were taking place between different departments within BCUHB with a view to agreeing a protocol to establish an appropriate care pathway for patients presenting to the hospital with an infected prosthesis, however nothing had been finalised regarding the same.

Part 2 - Furthermore evidence indicated that although it was always intended that antibiotics would be administered once the patient's knee had been aspirated, there was a delay of almost two hours between this procedure and the administration of antibiotics (a delay which was explained by being due to "normal hospital procedures")



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Therefore please find enclosed two working action plans relating to this case. The action plans will be scrutinized by the Assistant Director or Nursing as well as the Hospital Medical Director and will be monitored by the at the Quality and Safety Group to ensure timely progress.

Yours sincerely

A handwritten signature in black ink, appearing to read 'E. Moore'.

Mr Evan Moore
Executive Medical Director

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