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

Bloc 5, Llys Carlton, Parc Busnes Llanelwy, Llanelwy, LL17 0JG

Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

[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
Susan Merton

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 Susan Merton.

I would like to begin by offering my deepest condolences to the family and friends of Ms Merton, and I apologise for the concerns identified at the inquest that have given rise to your notice. I also apologise that this is the second notice you have issued in regards to the completion of actions following serious incident investigations.

I would like to assure you that direct conversations have been held with the responsible service and we are providing close oversight of quality and safety in that area.

As outlined in my response to the Regulation 28 regarding Mr Hurst, we changed our serious incident process in April 2021. From this date all investigation reports are submitted 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. A report without an action plan would not be accepted. I am very disappointed that our service did not complete an action plan when they should have done, nor was it completed on the right template when it was. Our new process ensures this cannot happen.

We are also now tracking actions from these investigation reports and action plans through our Datix patient safety system and auditing compliance with action completion timeframes and evidence.

This new process covers incidents from April 2021 onwards. We recognise the case of Ms Merton, and Mr Hurst, occurred prior to this, so we have appointed a clinician to undertake a review of historic action plans to ensure actions are completed and evidence is available. This person commenced in post in November 2021, 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. This work will continue until we are assured of prior action plan completion.

I hope this letter offers you assurance that we have implemented a new system to address the concerns and provide greater oversight and assurance in the future. I also hope that our work to review action plans prior to the new process also offers assurance to you.

One again, please may I offer my condolences to the loved ones of Ms Hurst and my apologies for the concerns you have identified on this and other occasions.

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

Yours sincerely

[redacted]

Prif Weithredwr
Chief Executive