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

Your ref/eich cyf:
Our ref/ein cyf: [redacted]
Date/Dyddiad: 16th April 2015
Tel/ffôn: 01443 744800
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Dept/adran: Patient Care & Safety

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

Dear Mr Barkley,

Re: Regulation 28 Coroner's Rules: Mr Barrie Lewis

I refer to your correspondence received on 19th February 2015, enclosing the Regulation 28 report, which details the areas of concern following your conclusion of the inquest on 18th February 2015 relating to the death of Mr Barrie Lewis on 31st August 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. A robust action has been developed to minimise the risk of any recurrence.

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

   A corrective Action Plan for Improvement was developed to capture the Health Boards comprehensive response; this is attached.

2. **Actions implemented**

I can confirm that the actions have been taken forward by the Health Board to improve communication and documentation including a review of the Care Treatment Plan Policy and Procedures within outpatients department, development of a new procedure on the role of the duty officer and improved monitoring of recording systems and processes.

The progress made with implementing the action plan as at 16th April 2015 is reflected in the action 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 Lewis and that effective action has now been taken to mitigate reoccurrence of similar tragic incidents.