

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust



Pencadlys Rhanbarthol Ambiwlans a Chanolfan Cyfathrebu Clinigol Regional Ambulance Headquarters and Clinical Contact Centre Tŷ Vantage Point / Vantage Point House, Tŷ Coch Way, Cwmbran NP44 7HF

www.ambulance.wales.nhs.uk

CHAIR AND CHIEF EXECUTIVE'S OFFICE

Your Ref: Our Ref:

9 June 2016

PRIVATE AND CONFIDENTIAL

Mr Graeme Hughes HM Assistant Coroner South Wales Central Area Coroner's Office 1st Floor, Rock Grounds Aberdare CF44 7AE

Dear Mr Hughes

Re Ronald Hamer (Deceased)

I am writing in response to your letter dated 20 April 2016 and the Regulation 28 Report to Prevent Future Deaths issued by your office, following the inquest of Mr Ronald Hamer (Deceased). I would like to provide you with assurance that we are making progress with the actions being led by named individual staff and partners in order to take forward the key actions for improvement. Please find attached a copy of the Action Plan that the Welsh Ambulance Services NHS Trust has developed as a result of this Regulation 28.

I can assure you that as a consequence of this case we have learned lessons as an Organisation which are being monitored through a Task and Finish Group of senior staff, led by the Director of Quality, Safety and Patient Experience. I would also like to assure you that the monitoring of the actions and agreed timescales will be scrutinised through the Trust Board Quality, Patient Experience and Safety Committee.

In addition to the Regulation 28 requirements I would like to extend an invite to you to meet with the Director of Operations and the Medical Director who will be able to provide you with an overview of the new and pioneering Clinical Response Model and also the context of the events that were occurring across NHS Wales on the 8 February 2016.



Please do not hesitate to contact me if you have any questions with regards to the action plan.

Yours sincerely

Tracy Myhill

Chief Executive

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