

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust



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CHAIR AND CHIEF EXECUTIVE'S OFFICE

Our Ref: TM329/WH/ET

19 October 2016

PRIVATE AND CONFIDENTIAL

Mr John Gittins
HM Coroner
North Wales (East and Central Area)
County Hall
Wynnstay Road
Ruthin
LL15 1YN

Dear Mr Gittins

I am writing in response to your letter dated 26th August 2016 and the Regulation 28 Report to Prevent Future Deaths issued by your office following the inquest of Mrs Pamela June Conway (Deceased). I would like to provide you with the assurance that we have made progress against key actions which are all identified in the attached action plan. I can confirm that the most significant impact is as a result of the Welsh Health Circular (NHS Wales Hospital Handover Guidance) issued by Director General of the NHS Wales, on 5 May 2016.

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's Quality, Patient Experience and Safety Committee.



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

On a more general note, I look forward to meeting you and colleagues in your coronial area to discuss areas of concerns to us all as we discussed in the Summer.

Yours sincerely

Tracy Myhill Chief Executive

Tracy Myhill

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