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

Your Ref/eich cyf:
Our Ref/ein cyf: 19/3103/INQ
Date/dyddiad: 23rd January 2020
Tel/ffôn: 01443 744800
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Dept/adran: Concerns Team, Patient Care & Safety

Private & Confidential
Graeme Hughes
Her Majesty's Acting Senior Coroner
South Wales Central Coroner Area
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

Dear Mr Hughes

RE: Regulation 28 – Connor Davies

Thank you for the correspondence dated the 5th December 2019 in relation to the above Regulation 28, which details the areas of concern following the conclusion of the inquest held on the 29th November 2019 in relation to the death of Connor Davies.

Please be assured that the Health Board has taken this matter extremely seriously and an action plan has been developed to address the matters raised during the inquest. A copy of the action plan is attached. You will note that action to address the issues raised are currently ongoing. All outstanding actions are being implemented by the Mental Health Directorate, who will ensure that there is evidence to support the completed action plan which will be monitored through the Service and Health Board Governance structures.

I sincerely hope that this information will reassure you that the Health Board has learnt important lessons from the investigation into the care provided to Mr Davies and that effective action is being undertaken to prevent further deaths.

I would like to convey once again my deepest sympathy and sincere apologies to Mr Davies' family for the failings identified.

Yours sincerely

Dr Sharon Hopkins
Chief Executive Officer

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ACTION PLAN FOR IMPROVEMENT	
Reference	**Regulation 28 Report – Ref17108.** **MHU – W122574**
Directorate	Mental Health
Lead Officer for Action Plan (name & title)	Fiona Thomas
Date action plan commenced	15th January 2019
Synopsis of Concern	That when appointments are cancelled there is no clinical input as to the need of individual patients for more urgent referrals and thus a patient who is in serious need of an appointment may 'fall through the net'.

Action Needed	Lead	Deadline date for Completion	Progress & Evidence	Monitoring Arrangements
To review the existing process that determines clinical priority for rebooking of patient appointments following cancellation of clinics across the directorate.	Clinical Director	15th April 2020		Management Team Meeting
Revise the process to ensure that when appointments are cancelled a robust system is in place to triage the patient's clinical need and prioritise allocation of appointments as required.	Locality Managers	30th June 2020		Quality, Safety & Risk Meeting
Ensure that all clinical and administrative staff who are involved in cancelling and rebooking of appointments are trained in the agreed process and that there is an audit trail to demonstrate this.	Locality Managers	31st July 2020		Quality, Safety & Risk Meeting
Audit the new process to determine compliance at specific check points as agreed.	Clinical Director	31st October 2020		Quality, Safety & Risk Meeting