Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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

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

John Gittins
HM Senior Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin LL15 1YN

Ein cyf / Our ref: [redacted]
Eichcyf / Your ref:
☎: 03000 840135
Gofynnwch am / Ask for: [redacted]
E-bost / Email: [redacted]
Dyddiad / Date: 16 April 2025

Dear Mr Gittins,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Ann Margaret Cotgrove

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 21 February 2025, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Mrs Cotgrove.

I would like to begin by offering my deepest condolences to the family of Mrs Cotgrove.

As you know, the Board is committed to building a learning and improving organisation and we take all Prevention of Future Death Notices very seriously. In the notice, you highlighted your concerns that whilst expert advice from a specialist tertiary hospital had been sought, there was no documented process or evidence in relation this

The issues identified in your notice were shared with the clinical team involved in this case immediately after the inquest for reflection and learning.

The learning contained in your notice has also been shared with our Reducing Avoidable Mortality Group at its meeting in April 2025. This group leads on our work across North Wales to learn from deaths and reduce avoidable mortality with representatives attending from all services.

However, we felt that the absolute necessity for the documentation of discussions between clinicians, particularly when seeking opinion from a tertiary centre, is an important learning point to widely share.

As such, we have developed a case summary presentation which our Central Health Community Medical Director will share across their services through clinical governance meetings. This will help ensure all services learn from this case. We will also be sharing the case summary with our other two acute hospital Medical Directors for wider cascade.

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

In addition, it is important we recognise the challenges our clinical staff have with our current record keeping arrangements, which includes some paper records and some electronic records (which can be disjointed). As you know, the Health Board is actively progressing an integrated digital solution and we believe this will significantly improve the quality of patient records – the Health Board is at the forefront of this work across Wales. We have developed an Outline Business Case and this is due for approval at our Board in June 2025, before submission to the Welsh Government in July 2025.

I hope this letter sets out for you the actions that we are taking to address the concerns you raised.

I would be happy to meet with you and discuss our work to improve patient safety in more detail or provide further information and assurance should that be helpful.

Once again, I offer my deepest condolences to the family of Mrs Cotgrove for their loss.

Yours sincerely

[redacted]

[redacted]
Cyfarwyddwr Gweithredol Nyrsio a Bydwreigiaeth
Executive Director of Nursing and Midwifery

cc [redacted] Deputy Director for Legal Services