



Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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Llanellwyl, LL17 0JG

Block 5, Carlton Court, St Asaph Business
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Kate Robertson
HM Senior Coroner
North Wales (West)
HM Coroner's Office
Shirehall Street
Caernarfon LL55 1SH

Ein cyf / Our ref: WINQ1875

Eich cyf / Your ref:

Ffôn / Phone: 03000 840135

Gofynnwch am / Ask for: Matthew Joyes

E-bost / Email: matthew.joyes@wales.nhs.uk

Dyddiad / Date: 16 July 2025

Dear Ms Robertson,

**RE: REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Etta Lili Stockwell-Parry**

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 21st May 2025, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Etta Lili Stockwell-Parry.

I would like to begin by offering my deepest condolences to the parents and family of Etta. I will be meeting Mr. & Mrs. Stockwell-Parry in September and I will personally apologise to them, listen to their experience and discuss what we have done and to learn from this tragic event. You found that Etta's death in July 2023 was contributed to by neglect with several missed opportunities that may have changed the outcome. On behalf of the Health Board, I extend our deepest apologies to Mr. & Mrs. Stockwell-Parry and all those affected by this tragedy.

In the notice, you highlighted your concern that the neonatal investigation was not thorough, and that there was insufficient contextual sharing of the investigation or its findings from a neonatal or maternity perspective. In addition, the memoranda sent to staff highlighting the learning did not include context or narrative around the circumstances of investigation.

Following your findings, significant consideration has been given as to next steps. A group of senior nursing, midwifery, medical and patient safety staff met to draft a comprehensive response, and the Executive Director of Nursing and Midwifery (as our executive lead for patient safety) has provided leadership oversight.

I understand you recently met with the Executive Director of Nursing and Midwifery in respect of investigation quality, and I hope this has given you some further assurances on the work we have undertaken and will continue to take forward.

In relation to investigations, as you know this is an area of improvement I have prioritised. Last year, a new Integrated Concerns Policy was approved in June 2024 by the Board

and implemented in September 2024. This new policy provides a single, integrated approach to incident, complaint and mortality reviews and investigations. The patient safety, complaint and mortality review teams are now working together as a more integrated hub to coordinate investigations, supported by a daily hub review meeting and a weekly clinical executive led meeting. A new training programme for investigating officers has been implemented. The new policy also requires that all those involved in an incident are engaged in the process including receiving the sharing of information.

Although these changes came after Etta's tragic death and subsequent investigation in 2023, they form the basis of improvements that has changed how the Health Board investigates serious matters now and into the future.

Furthermore, work is being finalised to improve how learning is shared once a review or investigation is completed. A learning repository is being developed which is a key digital initiative designed to support our journey toward becoming a learning and self-improving organisation. This is believed to be the first of its kind in Wales.

The system will serve as a centralised, searchable repository that integrates data from multiple sources databases such as Datix (for incident and complaints), Greatix (system of positive feedback for learning), Civica (for patient feedback), audits, mortality reviews and more. Staff will be able to access relevant learning content, receive targeted updates, and contribute their own feedback.

It will capture learning from a wide range of sources - both structured and unstructured - including incident reports. It will ensure that all content is quality-checked and appropriately categorised, support version control and user subscriptions making it easy for staff to access relevant learning and for administrators to manage content effectively. It will improve 'closing the loop' by capturing feedback on how learning is applied in practice. It is being tested currently with further evaluation and staff engagement during summer and a plan to roll out across the Health Board from November 2025.

The changes being made, such as the new Integrated Concerns Policy and new Learning Repository, are part of a range of interventions being made to fundamentally change how the Health Board operates with the intention of building a sustainable organisation for the future.

I am also leading work to improve how the organisation functions as part of a programme called Foundations for the Future, and this will have a range of interventions of which the closer integration of women's services and neonatal services will be an outcome. This will also improve the way investigations and learning is conducted across these two deeply interconnected services).

Finally, I am also aware the Executive Director of Nursing and Midwifery has instigated a number of immediate safety changes following your notice. The first is a clear direction that investigations across women's services and neonatal services will have a single investigation officer (as opposed to the practice that occurred in Etta's case where



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separate reviews were undertaken and then brought together). This will directly address quality and consistency, in line with how all other services operate. In addition, a directive has been issued that investigations across women's services will use the framework and templates within the Integrated Concerns Policy (as opposed to the PMRT tool which was used for Etta's case). The national tool will continue to be used however investigations will follow the established Health Board format. We have also appointed a new quality governance officer into neonatal services which will ensure access to local specialist skills and capacity for investigations and reviews.

I hope this letter sets out for you the actions we have taken to ensure the concerns raised by yourself are being addressed and mitigated. I will reiterate my commitment, and that of the Health Board, to fully address the concerns regarding investigations.

I would be happy to meet with you and discuss the plans in more detail, or provide further information and assurance should that be helpful.

Once again, I offer my deepest condolences to the parents and family of Etta.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'Carol Shillabeer'.

Carol Shillabeer
Prif Weithredwr/Chief Executive

cc Angela Wood, Executive Director of Nursing and Midwifery
Matthew Joyes, Deputy Director for Legal Services