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[redacted]

Eich cyf/Your Ref: [redacted]

Dyddiad/Date: 25 June 2026

Private & Confidential
HMC Rachel Knight
Coroner's office
The old courthouse
Courthouse street
Pontypridd
CF37 1JW

Dear Miss Knight,

Regulation 28: Report to prevent Future Deaths - Inquest into the death of Summer Rae Mant

Thank you for your Regulation 28 Report issued following the inquest into the death of Summer Rae Mant.

On behalf of Cwm Taf Morgannwg University Health Board (CTMUHB), I would like to express our sincere condolences to Summer's family. We are grateful to you for identifying matters of concern arising from the evidence heard at inquest and for the opportunity to set out the actions taken and planned in response.

The Health Board acknowledges the concerns raised in relation to a delay in obtaining adrenaline during resuscitation, variation in crash trolley layout and design and the risk posed by inconsistent systems for rotational junior doctors.

It is further acknowledged that the Health Board accepts that variation in the visual layout and accessibility of resuscitation equipment presents a human factors risk, particularly in time-critical emergency situations.

The Health Board has actively contributed to the Welsh Government-led All-Wales response to this Regulation 28 report, recognising the importance of a consistent national approach to patient safety improvement.

[redacted]

In addition, following receipt of the Regulation 28 report, the Health Board established a multidisciplinary Task and Finish Group to oversee the local response and provide assurance of delivery. This group includes representation from resuscitation services, pharmacy, clinical services and clinical education.

The group has:

- Developed and is overseeing delivery of a comprehensive Action Plan
- Ensured actions are clinically informed and aligned to human factors principles
- Provided coordinated oversight across all relevant services and sites
- Established a clear mechanism for monitoring progress and evidencing assurance

The Action Plan is being used as the Health Board's live assurance document and is supported by regular oversight through Patient Safety and Legal Services governance arrangements, including scheduled follow-up meetings to monitor progress and delivery.

The Health Board has undertaken a comprehensive review of resuscitation trolley arrangements across all acute hospital sites. This confirmed that whilst the contents of cardiac arrest drug trays are standardised in line with Resuscitation Council guidance, there remained variation in visual layout and presentation, particularly at Princess of Wales Hospital (POW), which presents a recognised human factors risk in time-critical situations. In response, immediate action has been taken to align POW paediatric resuscitation trolleys with the established model used at Prince Charles Hospital and Royal Glamorgan Hospital. This includes the removal of red paediatric drug boxes and the introduction of a clear tray system to improve visibility and rapid access to emergency medication. Implementation is being supported through a structured rollout programme, including ward-based engagement, communication and standardised visual guidance materials.

This programme of standardisation is being delivered in a phased and clinically led manner and extends beyond paediatric areas. Neonatal resuscitation arrangements, recognised as requiring a distinct approach, have been reviewed, with minor inconsistencies identified and actions agreed to ensure alignment across sites. In addition, all clinical environments where a resuscitation event may occur including wards, theatres, emergency departments and specialist services are being incorporated within the scope of this work to ensure consistency and reduce variation across the Health Board

In parallel, a review of medicines governance identified inconsistencies between Pharmacy Standard Operating Procedures and the overarching Resuscitation Policy, particularly in relation to roles and responsibilities for checking, replenishment and expiry monitoring.

These risks have been addressed through clear delineation of responsibilities, with nursing teams responsible for daily checks of resuscitation trolleys and Pharmacy responsible for ongoing stock management and expiry control. Work is underway to rationalise and align all relevant policies and SOPs, ensuring that a single, current and consistent set of guidance is available across the organisation, supported by appropriate document control arrangements.

The Health Board has also strengthened training and induction arrangements to address human factors risks associated with staff unfamiliarity. Whilst nursing staff already receive resuscitation trolley orientation as part of induction and mandatory training, gaps were identified within medical induction, particularly for rotational and out-of-hours staff. In response, work is underway with Medical Education to embed resuscitation trolley orientation within formal induction programmes for all incoming medical staff. Interim arrangements have been introduced to provide immediate assurance, alongside the development of updated training resources, including visual guides and instructional materials, to support consistent staff familiarisation with the standardised trolley layout.

The Health Board recognises the seriousness of the concerns raised and is committed to ensuring that robust, standardised systems are in place to support safe and effective emergency care.

Significant progress has already been made, with strong governance arrangements now in place to oversee delivery and ensure sustained improvement.

We hope this response provides assurance that appropriate and proportionate action is being taken to mitigate the risks identified and prevent future deaths.

If you require further information please liaise with [redacted], Lead for Legal Services [redacted] who will be able to assist.

Yours sincerely,

[redacted]

Prif Weithredwr/Chief Executive

[redacted]