



Ein cyf/Our ref:

Rachel Knight  
HM Coroner South Wales Central  
Coroner's Office  
The Old Courthouse  
Courthouse Street  
Pontypridd  
CF37 1JW  
[REDACTED]

26 June 2026

Dear Ms Knight

**Regulation 28 Prevention of Future Deaths report – Summer Rae Mant (deceased)**

Thank you for your correspondence of 27 February, addressed to my predecessor, enclosing a Regulation 28 Prevention of Future Deaths report following the inquest into the death of Summer Rae Mant.

I would like to express my sincere condolences to Summer's family. I recognise that this has been an incredibly difficult time, and my thoughts remain with them.

It is my clear expectation that healthcare professionals working within the NHS provide high-quality care in line with the standards expected of their respective professions. It is deeply concerning when care falls below those standards. Where harm occurs, I expect the NHS to learn from these events and take action to prevent recurrence. Regulation 28 reports are a vital part of this process.

I note your response was also addressed to the Chief Executives of all health boards and Velindre University NHS Trust, and am therefore providing a joint response, as supported in your report.

I have carefully considered the matters of concern you raised, in particular the delay in obtaining adrenaline from a crash trolley at Prince Charles Hospital, Merthyr Tydfil, which was identified as a contributory factor.

My officials have worked with NHS Wales Performance and Improvement (NHSWP&I) to assess current arrangements across NHS Wales in relation to crash trolley standardisation. This work found that the contents of all resuscitation trolleys and boxes across Wales are aligned to the Resuscitation Council UK Guidelines [Quality Standards: Acute care equipment](#)

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

[and drug lists | Resuscitation Council UK](#), which alongside a requirement to have a standardised list of medicines which are always available, allows for the specific availability of equipment and drugs to be determined locally.

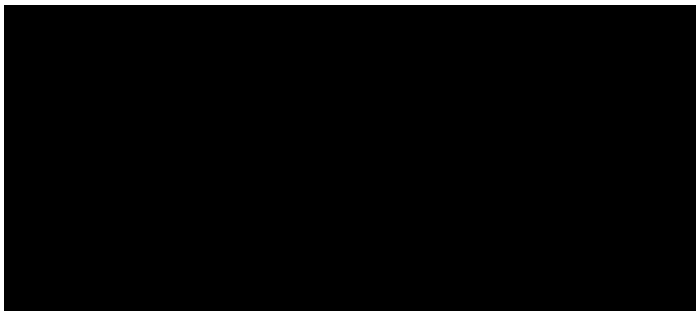
The Welsh Government will require NHSP&I to convene a group of resuscitation experts from Wales to review whether any medicines other than those on the Resuscitation Council UK's standard list should be available on all crash trolleys in hospitals. The group will undertake work to reduce variation in crash trolley layout for both adults and paediatrics, ensuring adherence to Resuscitation Council UK guidelines.

This group will also work with the All Wales Drug Contracting Committee to select the most appropriate preparation of each these medicines to be stocked on crash trolleys and ensure they are all available to all health boards and trusts through a single all-Wales contract with suppliers. This will ensure standardised packaging and branding of products on crash trolleys for any products where this is not already the case. This approach will ensure that procurement decisions take account not only of cost but also human factors that may influence usability in emergency situations, alongside safety, standardisation, and supply chain resilience.

The Welsh Government will direct health boards and trusts to only use nationally procured standardised products on crash trolleys and follow the agreed layout.

I trust this response demonstrates the seriousness with which we consider reports to prevent future deaths, and our commitment to working collaboratively with NHS organisations and professional groups to reduce the risk of avoidable patient harm.

Yours sincerely,



Y Gweinidog Cabinet dros Iechyd a Gofal  
Cabinet Minister for Health and Care

Cc Chief Executives of NHS Wales health boards and Velindre University NHS Trust