Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

[redacted]

Swyddfa'r Prif Weithredwr a'r Cadeirydd

Chair and Chief Executive's Office

[redacted]

17th April 2023

**PRIVATE & CONFIDENTIAL**
Ms Kate Sutherland
Assistant Coroner for North wales (East and Central)
[redacted]

Dear Ms. Sutherland

**Re: Mr. David Colin Strachan**

I write in response to the Prevention of Future Deaths Report issued to this Trust on the 20th February 2023, following the inquest in relation to Mr. David Colin Strachan.

The matters of concern that you have asked the Trust to consider are:

***"The causes of the ambulance delay were that all available resources were managing incidents of a higher acuity or the same category but registered prior and there were significant handover delays across all BCUHB sites.***

***The matters of concern herein are longstanding and multifactorial and despite proposed future action significant concerns remain. The Welsh Ambulance Service NHS Trust and Health Board maintain that they are continuing to work closely in order to address handover delays and yet any improvements appear extremely limiting. Deaths are occurring and will continue to occur as a result of delayed ambulance attendances caused by these multifactorial issues."***

I have already shared with you, in our response in relation to Mr. Raymond Gillespie, the actions the Trust has already taken as a response to the concerns regarding patient safety at times

when ambulances are unavailable. Additionally, we have shared with you the measures that are currently in place such as the Clinical Safety Plan and the Regional Escalation Action Plan. I will not repeat those within this response to you, however, the Clinical Safety Plan was revisited in December 2022 and I attach at appendix 1, a copy of the latest plan.

The Trust has previously provided evidence to coroners pan-Wales regarding the actions that have been taken in order to reduce the lost hours and improve our response times for patients waiting in the community. In my response to you regarding Mrs. Glynis Roberts, I shared a copy of the Reducing Patient Harm Action Plan that had been tabled in our Trust Board meeting.

This Action Plan continues to be monitored, updated and tabled at Trust Board meetings. I attach for your reference copies of the plan, and associated reports, that was presented to the Trust Board on the 26th January 2023 and 30th March 2023.

Presented alongside the plan are reports regarding the actions being taken to mitigate in real time, avoidable patient harm, in the context of extreme and sustained pressure across urgent and emergency care. Please find these documents at appendix 2 – 4 attached.

While writing, I would like to extend my sincere condolences to Mr. Strachan's family on their sad loss. I would again like to extend the offer to meet with you to discuss our response in more detail and to provide you with any further assurances you may require regarding our commitment to continued improvement to support the prevention of harm and future deaths.

Yours sincerely

[redacted]

[redacted]
**Chief Executive**

**Enc:**
App1 – Clinical Safety Plan
App 2 – Trust Board January 2023 Actions to Mitigate Avoidable Patient Harm
App 3 - Trust Board Progress of Actions to Mitigate Avoidable Patient Harm (March 2023)
App 4 - Improvement Plan March 2023 - Patient Harm Mitigation Action Plan