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]

2 November 2023

PRIVATE & CONFIDENTIAL
Ms Kate Robertson
H.M. Senior Coroner for North West Wales
[redacted]

Dear Ms Robertson

Re: Mrs Mary Elizabeth Jones

I write in response to the Prevent of Future Deaths Report issued to this Trust on the 10 July 2023, following the inquest. Firstly I would like to apologise for the delay in responding to you in relation to this matter. Also, can I please pass on apologies from [redacted], Assistant Director of Quality and Nursing Directorate.

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

This is a further Report, of several by me, as both Senior Coroner for North West Wales and Assistant Coroner for North Wales East & Central relating to matters of ambulance delays and inability to offload patients in a timely manner into Emergency Departments across North Wales.

Evidence was heard at the Inquest that the initial delays experienced by Mary Elizabeth Jones whilst awaiting an ambulance and waiting in the rear of the ambulance possibly contributed indirectly to her existing frailty. Whilst not in themselves causative of Mrs Jones' death it remains a significant concern that despite evidence of improvements by the Health Board and WAST upon which I have previously been provided, that even as recently as December 2022, unacceptably lengthy delays remain such as in the case of Mary Elizabeth Jones.

I have still not been presented with any meaningful evidence on the involvement of Local Authorities in the considerations by WAST and BCUHB of lack of patient flow due to social care deficiencies.

At this time and in specific response to this Prevention of Future Deaths Report, the Trust does not propose to take any further action or new actions in relation to this matter. The Trust is taking all possible steps within its control to ensure availability of resources to respond to Red and Amber calls. The Trust also seeks to secure full support from Welsh Government, the wider NHS and local Government to ensure appropriate clinical risk management across the urgent and emergency care pathways to release resources with the Trust.

The Trust has previously shared with you that it is represented on the North Wales Regional Partnership Board, which brings together a range of statutory and non-statutory partners, including Local Authority representation at both officer and member level, focused on improving collaborative services provided to the people of North Wales, including older people.

The Trust has evidenced this work through the comprehensive details of all the actions that we have taken to date, and I have also shared with you the measures that are currently in place, such as the Clinical Safety Plan and the Regional Escalation Action Plan. I have not attached copies of these Plans again, as I have previously supplied them.

I have shared with you copies of the Real-time Mitigation Report and the Reducing Patient Harm Action Plan, both of which were presented to the Public Trust Board on the 27 July 2023. This Report is regularly presented to, and reviewed by, the Trust Board and I hope this offers you assurance that this matter continues to remain a significant risk and a matter of attention to the full Trust Board.

While the Trust fully supports the need to issue a Report under Paragraph 7, Schedule 5, of the Coroners & Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, we do not believe that we are the authority with the “power to take such actions”. Therefore, I respectfully request your consideration as to any further actions you feel the Trust could take, over and above those we have already shared with you. Equally, I would genuinely welcome any suggestions you may have regarding actions we might take or seek to take with our partners.

To reaffirm my earlier comment, we believe we have robust plans in place which are regularly critiqued and monitored throughout the organisation. The issues arising are presented to our full Trust Board and we liaise directly with the Health Boards and wider health and social care partners across Wales in order to secure their support to ensure that we respond to Red and Amber calls in a timely way.

While writing I would again like to offer my sincere condolences to Mrs Jones’s family on their sad loss. I would like to extend the offer to meet with you and leaders of other key organisations 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