



Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Bloc 5, Llys Carlton, Parc Busnes Llanellwly,
Llanellwly, LL17 0JG

Block 5, Carlton Court, St Asaph Business
Park, St Asaph, LL17 0JG

John Gittins
HM Senior Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin LL15 1YN

Ein cyf / Our ref:

Eich cyf / Your ref:

[REDACTED]
[REDACTED]
[REDACTED]

Dyddiad / Date: 28 May 2024

Dear Mr Gittins,

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Maureen Elizabeth Owens**

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 02 April 2024, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest into the death of Mrs Maureen Owens.

I would like to begin by offering my deepest condolences to the family and friends of Mrs Owens.

In the notice, you highlighted your concerns that there is inadequate knowledge of the use of the Adult Critical Care Transfer Service (ACCTS) and its operation across the whole of the Health Board, including clinical site managers as well as clinicians and nursing staff.

Following the inquest, the Emergency Medical Retrieval and Transfer Service (EMRTS) have examined the patient records and [REDACTED], EMRTS National Director, has written to me with their findings.

They confirm that it is correct that the ACCTS were not contacted about the transfer of Mrs Owens, and from their review confirm Mrs Owens did not meet the current criteria for ACCTS referral or transfer since the proposed transfer was a ward to ward transfer and there were no critical care needs identified.

The ACCTS service is currently only commissioned to transfer patients with critical care requirements. Therefore, the referral was correctly made to the Welsh Ambulance Service Trust and the clinical urgency of the transfer should have determined the speed of response and transfer.

As you know, significant work is already underway to improve Urgent and Emergency Care as part of the Welsh Government Six Goals Programme as we have detailed in other responses to you previously. Specifically in relation to these concerns about staff

awareness of the transfer procedures, I asked our Associate Director of Urgent and Emergency Care to develop improvement actions, which I have summarised below.

Whilst there is a confirmed process in place for requesting immediate transfers that is utilised effectively on a daily basis across North Wales, in response to your notice we have identified further learning and improvement is required to support all our staff and as such, we have agreed actions for implementation:

No.	Action/Objective	Delivery Date
1.	Re-share with all Integrated Health Communities (IHCs) the agreed transfer process and seek confirmation from them this has been cascaded	13/05/2024 (Complete)
2.	All acute sites to confirm site management teams as the single point of contact for emergency transfers from their respective sites	10/06/2024
3.	Health Board wide system focus on service provision required for intra-hospital transfers for specialties between Hub and spoke sites – a workshop date will be finalised (working closely with national commissioners)	01/08/2024
4.	Review the Patient Transfer Procedure (NU19) – this work is already underway led by a Head of Nursing and the Head of Patient Safety	01/08/2024
5.	Develop a monitoring process for transfers/repatriations in line with the All-Wales repatriation process as part of the Six Goals Programme for Urgent and Emergency Care	01/09/2024

Delivery against the above actions will be overseen by the Associate Director for Urgent and Emergency Care who will provide assurance to the Urgent and Emergency Care Programme Group that the above actions have been delivered.

I hope this letter sets out for you the actions that we are taking to ensure the concerns you raised are being addressed.

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

Once again, I offer my deepest condolences to the family and friends of Mrs Owens for their loss.



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Betsi Cadwaladr
University Health Board

Yours sincerely



**Cyfarwyddwr Meddygol Gweithredol / Dirprwy Prif Weithredwr Dros Dro
Executive Medical Director / Acting Deputy Chief Executive**

cc , Deputy Director of Quality