RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's publication policy (PDF).

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, John Adrian Gittins for the Coroner Area of North Wales (East and Central) in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of Janet Mary Nixon that concluded on **15th July 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, [redacted] **Chief Executive Officer for the Respondent** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE – 16/09/2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: Whilst it is acknowledged that there are multifactorial reasons for so-called ambulance delays, representatives of WAST gave evidence that delays in off loading patients at hospital remain one of the most significant elements in relation to these issues. I was also advised that there is currently work being undertaken to ensure that in future, there would not be more than a 45 minute wait for the handover of patients and that such a timescale would provide significant improvements in relation to the availability of resources. However it was not possible to provide a reliable timeframe for this provision, and therefore I remain concerned that it is likely that lives will continue to be lost, until such improvements take effect.

3.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. [If no action is proposed please explain why here]. *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* **Optimising the Trust's Clinical Model** The Trust has established a dedicated Call Flow Improvement Programme to refine its clinical model and improve the availability and use of ambulance resources. This brings together a number of interdependent workstreams rather than relying on a single intervention. The programme includes: • strengthening clinical review and prioritisation so that patients receive a response proportionate to their clinical need and ambulance capacity is protected for those who most need an emergency response; • improving the management of urgent care requests, including greater use of planned responses and urgent care resources where a traditional emergency ambulance is not clinically required; • developing earlier clinical assessment and alternative care options for patients presenting with breathing difficulties, where this can be achieved safely; • improving Clinical Navigator processes to reduce avoidable call-handling activity and enable clinicians to assess patients more quickly; • improving the pathway from the initial call to definitive treatment for time-critical conditions, initially including stroke; • reducing avoidable variation in on-scene times for clinically appropriate patient groups, initially including stroke and ST-elevation myocardial infarction; • improving dispatch decisions and resource positioning so that available ambulances are used as effectively and consistently as possible; and

- strengthening pathways for people who have fallen, including the use of appropriate responders who can provide earlier assessment and intervention where an emergency ambulance is not required.

These areas have been selected because each can contribute to improved ambulance availability and a safer, more responsive service. Some interventions are intended to reduce the number of incidents requiring an emergency ambulance, while others are intended to reduce delay or variation at a particular stage of the patient pathway. Collectively, they are intended to release capacity and improve the Trust's ability to respond to patients waiting in the community. We are developing clear baseline measures and improvement trajectories for each workstream. These will enable the Trust to assess whether individual interventions are delivering the expected benefits, identify where progress differs from expectation, test and refine the assumptions on which plans have been based, and focus further action on areas where improvement is not being achieved.

Progress is subject to clinical safety assessment, performance monitoring and executive oversight. Workstream assumptions and trajectories will continue to be reviewed and adjusted in response to evidence, operational experience and any unintended consequences. This is intended to ensure that improvement in one part of the pathway does not introduce additional risk elsewhere.

Reducing avoidable conveyance

An important part of the Trust's developing clinical model is ensuring that, where it is safe and appropriate, patients receive care closer to home or through an alternative service rather than being transported to an emergency department.

The Trust is strengthening remote clinical assessment, "hear and treat" and "see and treat" arrangements. We are also working to improve access to services such as same-day emergency care, urgent primary care and locally available community pathways.

The effectiveness of this work is dependent upon those alternative pathways being available, accessible and sufficiently responsive at the time they are needed. Ambulance clinicians cannot safely avoid conveyance simply because an emergency department is under pressure. They must have access to an appropriate alternative service that can accept the patient and meet their clinical needs.

For this reason, the continuing development of the WAST clinical model and the development of a clinically led Single Point of Access within Betsi Cadwaladr University Health Board are closely linked. WAST can increase clinical triage and identify patients who may not require emergency department care, but the

	benefit can only be fully realised where the Health Board has the pathways and capacity to accept those patients safely and promptly. Joint work is therefore examining access to primary care, same-day emergency care, services for people who have fallen, call-before-convey arrangements and other community and urgent care pathways. Barriers to referral and acceptance are being identified and escalated through the appropriate joint governance arrangements. **Hospital handover improvement** The requirement to implement the 45-minute ambulance handover approach has been set nationally. On 1 May 2026, NHS Wales Performance and Improvement wrote to Health Boards and WAST setting out the need for partnership arrangements, implementation plans, agreed critical paths and ongoing assurance and escalation mechanisms. Betsi Cadwaladr University Health Board was one of the Health Boards identified for early prioritisation. WAST has actively supported the development and implementation of the North Wales plans. This has included executive, strategic, clinical and operational engagement; participation in site-based discussions; sharing operational data and learning; supporting implementation activity; and identifying the pathways and processes that could reduce conveyance or improve ambulance turnaround. There has been encouraging engagement and some evidence of improvement in parts of North Wales. However, the position is not yet sufficiently consistent or sustained for the Trust to provide assurance that no patient will wait longer than 45 minutes for handover, or to give an unconditional date by which that position will be achieved across all three acute hospital sites. The Trust will continue to work constructively with the Health Board and NHS Wales Performance and Improvement, but it cannot itself create hospital capacity, staff receiving areas, improve movement through inpatient services or discharge patients from hospital. It would therefore be misleading to suggest that refinement of the ambulance clinical model alone can resolve hospital handover delay.

	Monitoring, assurance and escalation The Trust is committed to demonstrating improvement through evidence. We will continue to monitor both the individual components of our Call Flow Improvement Programme and their combined impact on ambulance availability and patient response. For hospital handover, monitoring will continue through local site arrangements, joint strategic governance, the Health Board's urgent and emergency care arrangements and wider national oversight. Where implementation differs from agreed plans, where improvement is not sustained or where new patient safety risks emerge, these matters will be escalated through the respective organisations and, where necessary, to national performance and accountability arrangements. This approach is deliberately based on measurable improvement rather than assurance through narrative alone. It allows both organisations to understand whether specific changes are working, distinguish short-term improvement from sustainable change, and take corrective action where expected benefits are not being realised.
4.	**DETAILS OF FURTHER ACTION PROPOSED** *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* The Trust recognises the gravity of the concern you have raised. We do not consider the current level of risk to patients waiting in the community to be acceptable, and we are not relying solely on wider system improvement. WAST is taking all reasonable steps within its control to improve clinical assessment, prioritisation, dispatch, urgent care responses, alternative pathways and ambulance availability. We are breaking this work into clearly defined areas, establishing baseline positions and improvement trajectories, and measuring whether each intervention is contributing to the overall result. At the same time, we must be open about the limits of what WAST can deliver independently. Sustainable improvement in ambulance handover in North Wales requires Betsi Cadwaladr University Health Board to provide timely acceptance of patients, effective emergency department and hospital flow, consistent access to alternative pathways and the capacity necessary to maintain those arrangements. WAST will support, influence, monitor and escalate this work, but it cannot deliver those Health Board responsibilities on the Health Board's behalf.

	For that reason, although we can provide assurance about the actions being taken and the governance through which they are being monitored, we cannot responsibly provide an unconditional date by which all ambulance handovers in North Wales will take place within 45 minutes. We will continue to press for the earliest possible and sustainable delivery, while being transparent about progress, risk and the interdependencies that remain. I would be pleased to meet with you to discuss this response, our clinical and operational improvement programme and our continuing work with Betsi Cadwaladr University Health Board in further detail.
	SIGNATURE  