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 North Wales (East and Central) in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of **Dorothy Evans** that concluded on **27/07/2026.**

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, [redacted], **Chief Executive Officer** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE 22nd September 2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: *The evidence provided to me at the inquest, both written and orally detailed multifactorial reasons for so-called ambulance delays, and it was acknowledged by the representative of WAST that lives are at risk as a result. Representations were also made whereby it was suggested to me that in essence there was nothing more which WAST could do to alleviate these issues and that only other agencies or organisations could affect change. However no evidence was made available as to which agencies were being referenced and the steps taken at the most senior levels to influence change, reduce delays and hence save lives.*
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.* The Trust is deeply sorry that Ms Evans did not receive the timely ambulance response she needed. We recognise that behind the operational pressures described in this response was a person waiting for help, and a family affected by the delay and its consequences.

The Trust accepts the need to take all reasonable action within its control to reduce this risk. There are actions within our direct control, and there are also actions we must continue to influence through Health Boards, NHS Wales Performance and Improvement, Welsh Government mechanisms and urgent and emergency care governance arrangements.

It is equally important that we provide a realistic and transparent account of the boundaries of the Trust's direct control. WAST can improve how calls are assessed, prioritised and managed, reduce avoidable conveyance where safe alternatives exist, optimise dispatch, and work to reduce unnecessary time spent at scene. However, once an ambulance arrives at hospital, responsibility for accepting the patient into the hospital's care and maintaining flow through the emergency department and wider hospital rests with the receiving Health Board.

This does not mean that WAST considers hospital handover delays to be a matter for other organisations alone. We have an important responsibility to use our influence, data, clinical expertise and operational relationships to support improvement, identify barriers and escalate concerns. We will continue to do so.
Examples of actions by WAST to date include:

- Collaborative series of meetings between the WAST Chief Operating Officer and senior operational leaders within the Health Board, sharing information on ambulance call activity to enable Health Board Colleagues to develop internal plans for improvement.
- Further direct meetings with myself as CEO and my Deputy, the Managing Director of NHS Performance and Improvement, other members of my executive team and senior leaders within the Health Boards (including BCUHB) to agree improvement trajectories to meet the handover 45 target.
- WAST has led on the development of a National Standard Operating Procedure. This document, developed by our Chief Operating Officer and shared across all organisations will be presented at the next National Leadership Board for agreement and sign off.

System partnership

In North Wales, the sustained delivery of ambulance handovers within 45 minutes is dependent upon the actions and capacity of Betsi Cadwaladr University Health Board (BCUHB), supported through the wider NHS Wales performance and accountability arrangements.

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. BCUHB 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.

The Trust will continue to work constructively with the Health Board and NHS Wales Performance and Improvement. While WAST cannot directly discharge patients from hospital or create inpatient capacity, we recognise that we have a continuing

responsibility to use our operational insight, clinical expertise and executive influence to support improvement and escalate risk where patients remain exposed to avoidable delay.

National Programmes

The Trust participates fully in a number of national improvement initiatives. Some are in early states of programme establishment, and the Trust is engaged and supporting delivery from inception. Given the system-wide dependencies of providing timely pre-hospital care, national programmes are critical levers in achieving system-level changes.

Community by Design (CBD)
CBD seeks to create "A Healthier Wales" through an integrated, sustainable, population focused system delivering care closer to home, with prevention and well-being at its core that meets the changing needs of the population. This Welsh Government led programme, chaired by the Chief Medical Officer, is set to be delivered through 3 core pillars of work each in turn led by an NHS Wales Chief Executive to deliver system wide transformation and improvement; Chronic Conditions; Urgent & Same Day Care; Prevention. WAST has been fully engaged and involved in early work to formally establish the programme, delivery mechanisms and prioritisation of the key improvement projects. WAST will have a role supporting and influencing all 3 pillars, however a key area of involvement will be the Urgent & Same Day Care workstream. Importantly, I am also a member of the Programme Board for this work.

Urgent & Emergency Care Programme
WAST is an active partner in the refreshed national 'Urgent & Emergency Care Programme' which has replaced the Six Goals programme. The programme has also identified three core pillars of work where we will have an active role supporting. Pillar 1 – Pre-hospital & Community, Pillar 2 – Front door & first 72 hours, Pillar 3 – Ward based flow & discharge.
This programme is in the early stages of development and WAST is a formal member and contributor supporting this work to establish and set the direction. I am Vice Chair of the Programme Board and one of our Associate Medical Directors is an attending member. It is anticipated that this should be an influential group that will be instrumental in addressing the issues at hand.

Single Point of Access (SPOA)
Improvement work to connect pre-hospital demand for care with senior Health Board clinicians to facilitate access to expertise in local treatment pathways was conceived under the former Six Goals programme. Following changes to programme structure, WAST are undertaking active work with NHS Performance & Improvement and Health Board clinical leads to improve the joint working with the SPOAs to safely increase the volume of patients on the WAST Integrated Care stack who can safely be managed by a GP or Health Board clinician within a remote SPOA setting. Where safe to do so, this will help to reduce the need for an ambulance response as patients are supported in the community or placed directly into an appropriate care pathway.
We have been and remain committed to working with partners to improve the impact of these SPOAs. We have frequently hosted visits from senior clinical leaders into the organisation to explore further ways in which our systems and processes can integrate together to improve outcomes for patients.

Monitoring, assurance and escalation
The Trust is committed to demonstrating improvement through evidence. We will continue to collect and analyse data surrounding our internal Call Flow Improvement Programme as well as contributing organizational data to national programmes and

	collaboratively monitor their combined impact on ambulance availability and patient response. Our approach is deliberately based on measurable improvement rather than assurance through narrative alone. It allows all 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. 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. In addition to this work and hopefully to offer further assurance that this is the highest of priorities for the organisation, we regularly meet as an executive team with Health Board Executive teams where the actions to address handover delays are a key focus. Coupled with interactions with the NHS Wales Joint Commissioning Committee (which include the Health Board CEO's), these exchanges are frequently focused on our principle clinical risks, our actions to address them, the content of our Integrated Medium Term Plan (IMTP) and how this plan aims to address the current challenge.
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 fully recognises the seriousness of the concern raised by the coroner. We do not regard the current risk to patients who are waiting in the community as acceptable, and we are continuing to take action within WAST's own control rather than depending only on improvement across the wider system. WAST is progressing all reasonable measures within its remit to strengthen clinical assessment, prioritisation, dispatch, urgent care response, access to alternative pathways and ambulance availability. This work is being taken forward through defined areas of improvement, with baseline positions, intended trajectories and measures in place to understand whether individual interventions are contributing to the overall improvement required. At the same time, we must be clear about what WAST can and cannot achieve on its own. Lasting improvement in ambulance handover performance in North Wales depends on Betsi Cadwaladr University Health Board being able to accept patients in a timely way, maintain effective flow through emergency departments and hospitals, provide consistent access to alternative pathways, and sustain the capacity needed to support those arrangements. We also recognise that hospital flow is affected by wider pressures across the health and care system, including limited social care capacity, availability of care home placements and access to community-based care across a large rural region, where the population is ageing and patients are increasingly presenting with more complex needs. WAST will continue to support this work, use its influence, monitor progress and escalate risk where necessary, but it cannot deliver those Health Board and wider system responsibilities independently. We will continue to seek the earliest sustainable improvement, while remaining open about progress, ongoing risks and the system dependencies that still need to be addressed. I would welcome the opportunity to meet with you to discuss this response,

	WAST's clinical and operational improvement programme, and our ongoing work with Betsi Cadwaladr University Health Board in more detail.
	SIGNATURE   **Chief Executive Officer, Welsh Ambulance Services University NHS Trust**