REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am John Adrian Gittins, Senior Coroner, for the coroner area of North Wales (East and Central)
2.	**DATE OF REPORT** 20th July 2026
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**THIS REPORT IS BEING SENT TO** **1. Welsh Ambulance Services University NHS Trust** Ty Elwy, Unit 7 Ffordd Richard Davies, St Asaph Business Park, St Asaph, Denbighshire LL15 2NG **2. Mabon Ap Gwynfor MS, Cabinet Secretary for Health and Social Care.** Welsh Government. You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th September 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

	Please note 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 names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** 1. Emergency services and urgent care a. Ambulance services 2. Delays a. Ambulance delays 3. Resources a. Availability of ambulances The length of waiting time for an ambulance response due to the unavailability of resources, whilst ambulances await the discharge of patients at hospitals
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On the 31st of October 2025, I commenced an investigation into the death of Janet Mary Nixon (DOB 1.11.57 DOD 30.10.25). The investigation concluded at the end of the inquest on the 15th of July 2026. The cause of death was recorded as being due to 1(a) Hypoxic brain injury, (b) Traumatic splenic laceration and major haemorrhage (operated) (c) Fall 2. Thrombocytopenia and the conclusion of the inquest was that of an accidental death
8.	**CIRCUMSTANCES OF DEATH** The circumstances of the death are that at 12.08 on the 21st of October 2025 a 999 call was made seeking the assistance of the ambulance service to Mrs Nixon, however there were no resources available for deployment at that time but at estimated time of arrival was advised as being three hours. Further 999 calls were made at 20.55 and 04.45 (22nd October), however due to resource

	issues, no ambulance was able to attend during this period and the first ambulance on scene was at 05.15, more than 17 hours after the first 999 call.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** 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.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to the family of the deceased. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

	SIGNATURE Dated 21st July 2026 Signature  Senior Coroner for North Wales (East and Central)