REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

William George Irvin WATSON, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Deputy Director of Urgent and Emergency Care, NHS Dorset Clinical Commissioning Group, Vespasian House, Barrack Road, Dorchester, Dorset, DT1 1TG** **2. NHS Kernow Clinical Commissioning Group, The Sedgemoor Centre, Priory Road, St Austell, Cornwall, PL25 5AS** **3. Copied to: CCG's at foot of this letter**
1	**CORONER** I am Andrew Cox, Assistant Coroner for the coroner area of Cornwall & Isles of Scilly.
2	**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	**INVESTIGATION and INQUEST** On 18 May 2017 an inquest was opened into the death of William George Irvin Watson who died on 11 May 2017 at the age of 82. I conducted the inquest on 20 June 2018. I found that Mr Watson died from: 1a) Pneumonia; 1b) Coronary Artery By-Pass Graft Surgery (post op) I recorded a Narrative Conclusion that Mr Watson died from complications of a necessary surgical procedure.
4	**CIRCUMSTANCES OF THE DEATH** On 24/1/17, Mr Watson was admitted acutely into Royal Cornwall Hospital with worsening angina. Coronary angiogram revealed severe multi-vessel disease. On 20/2/17, he underwent a triple CABG at Derriford hospital. He suffered a number of post-operative complications including an infected sternal wound that necessitated further surgery. On 13/4/17 he was transferred from Derriford to Treliske. On 22/4/17, a CT chest revealed a potential collection around the sternum and it was feared Mr Watson's wound had become re-infected. Arrangements were made to transfer him back to Derriford. There were a number of difficulties with that transfer. A clinician first contacted SWAST to arrange the transfer at 16:32. A response time of 40 minutes was indicated. At 18:09, following a deterioration in the patient's condition, the request was cancelled by which time an ambulance had not arrived. At 18:18 a doctor made a fresh request for an ambulance to effect a transfer to Derriford. A response time of one hour was indicated. An ambulance was allocated at 19:43 but three minutes later re-directed to a patient with a greater clinical need. At 20:25, a further ambulance was allocated but then again directed away. At 21:40 Mr Watson was re-classified as a Category 2 patient. An ambulance arrived on scene at 21:46 or nearly 2½ hours after the target time. At inquest, I heard from Ms Merriott of SWAST. It was candidly accepted that the reason for the delay was due to demand in the area at the time. It was further accepted that this was not an isolated incident and that there was and is currently a lack of resources to meet the existing demand. On 3/5/17, Mr Watson was discharged from Derriford back to Treliske. Again, there were difficulties with the transfer. The initial request was made at 13:48. The staff member who took the call missed the fact that a technician was required and this was not

	recognised until a vehicle came to collect Mr Watson at 16:00. At that point the booking service was asked to arrange a High Dependency transport which was done through Lifestar. I was told they are the only provider available in Cornwall. Mr Watson was collected at approximately 17:00 but did not reach Treliske until 19:40 hours approximately.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – **Emergency ambulance transport** I asked to be shown, in confidence, the correspondence that has passed between the NHS Dorset CCG and SWAST touching on the current lack of resource. It is plain there is a recognised problem and that considerable efforts have been made, notably through changes in the rota, to close the gap between the resource that is required and that which is available. It is equally clear that a significant performance gap remains indeed, as I understand the position, it is accepted that minimum performance standards cannot be met under the current financial provision. The obvious implication is that where an adequate response cannot be made because of insufficient funding to resource the service appropriately, the consequent delays may result in lives being lost. These could be avoidable deaths. It is my duty, in such circumstances, to make this report to you. I would be pleased to know: - How is the current financial shortfall to be remedied and by when? - By what date do you expect the minimum acceptable performance standards to be met? If a current constraint involves a lack of funding from central government I would be grateful if you would disclose to me, again in confidence, any relevant correspondence you may have had on the point. If it is necessary for me to do so, and I await your response, I will additionally direct this report to central government. **High Dependency Transport** I heard that the only provider of this service in Cornwall is Lifestar. I was informed that on occasions when Lifestar has no available resource it is necessary to contact providers from out of county. The evidence I heard from [redacted] was that there was a definite gap in service provision. Given that this involves the transport of patients with a High Dependency there is again a real risk that fatalities may arise in the future. I would be pleased to learn whether it is accepted by NHS Kernow CCG that there is a gap in service provision currently. If so, please set out how it is proposed to fill that gap and by when. **Non-emergency transfers** I was told at inquest that this service, commissioned by NHS Kernow, was being provided by a company called Ezec. I was further advised that its performance requirements are to collect 95% of patients within 1 hour and for short notice bookings, 50% were to be collected with 1 hour and 95% within 2 hours. I was informed that these targets are not being met.

	The inquest was advised that a new service provider will be taking on this business from April 2019. Of great concern to me was the revelation made at inquest that there are currently no compliant bids. It seems obvious that a patient who would ordinarily require a non-emergency transfer but who is kept waiting beyond acceptable performance standards may deteriorate and potentially have their life put at risk. In such circumstances I would be pleased to learn what steps the commissioners propose to put in place to remedy the difficulties that exist currently and the foreseeable, additional risks that will arise from April next year if action is not taken beforehand.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. I would be pleased to hear from you in reply to the matters identified above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 September 2018. I, the coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mr Watson's family, SWAST and RCHT. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** **[SIGNED BY CORONER]** **19/07/2018**

CC'd to:
NHS Dorset Clinical Commissioning Group;
NHS Bath and North East Somerset Clinical Commissioning Group;
NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group;
NHS Gloucestershire Clinical Commissioning Group;
NHS Kernow Clinical Commissioning Group;
NHS Northern, Eastern and Western Devon Clinical Commissioning Group;
NHS Somerset Clinical Commissioning Group;
NHS South Devon and Torbay Clinical Commissioning Group;
NHS Swindon Clinical Commissioning Group;
NHS Wiltshire Clinical Commissioning Group;
NHS South, Central and West Clinical Commissioning Support Unit.