	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the 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 7/11/22, I concluded an inquest into the death of David John Morganti, 87, who died on 10/4/22 in Royal Cornwall Hospital. The medical cause of death was recorded as: 1a) Catastrophic traumatic subdural haemorrhage 1b) 1c) II) Atrial fibrillation (on warfarin.) During the course of the inquest, evidence was heard that, following a fall with head injury, an ambulance was called which took nine hours to arrive. [redacted], a consultant neurosurgeon at University Hospital Plymouth stated: 'From the information we received at time of referral his level of consciousness deteriorated rapidly from 5: 00 PM, having been alert throughout the day. This suggests that had he reached hospital prior to his deterioration and his warfarin treatment been reversed rapidly, there is a chance that the continued bleeding which ultimately caused his death may have been slowed or stopped, in which case, he may have survived.' I recorded a Narrative Conclusion that: Mr Morganti died of an accident. The effects of the injuries he suffered were likely to have been exacerbated both by prescribed blood-thinning medication and, more particularly, by a delay in the arrival of an ambulance and his subsequent admission into hospital. I regret to advise that this is but the latest in a series of inquests conducted in the area where delays in the arrival of an ambulance and/or subsequent admission into Royal Cornwall Hospital have caused or contributed to a death. On 22/9/22, I concluded an inquest into the death of Mrs Winnie Barnes- Weeks. She died from: 1a] aspiration pneumonia 1b] fractured neck of femur 1c] fall 2] aortic stenosis, ischemic heart disease Winnie suffered injury on 29/11/21 when she slipped off her bed in her care home while trying to put on her shoes. Subsequently, she was found to have fractured her hip. Winnie lay on the floor for 19 hours awaiting an ambulance that never arrived. Eventually, the Registered Manager of the care home spoke to a local GP who organised a private ambulance. I concluded: 'Winnie died following an accident the effect of which was exacerbated by a long delay in an ambulance taking her to hospital.' On 18/10/22, I concluded an inquest into the death of Robert George Conybeare who

	died on 24/3/22 in Royal Cornwall Hospital. His cause of death was: 1A] traumatic intracranial haemorrhage II] frailty of old age. On 3/1/22, Mr Conybeare suffered a spontaneous collapse and struck his head. He was taken to Royal Cornwall Hospital where sub arachnoid haemorrhages were identified. By 13/1/22, he was assessed as medically fit for discharge, but suitable discharge arrangements could not be put in place. On 18/2/22, he suffered two falls in hospital and was subsequently found to have a sub-dural haemorrhage. He was transferred to University Hospital Plymouth for burr hole treatment. He was discharged back to Royal Cornwall Hospital on 11 March but deteriorated and died in the hospital on 24/3/22. I concluded: 'Mr Conybeare died from the effects of a combination of a spontaneous fall on 3/1/22 and an accident in Royal Cornwall Hospital on 17/2/22.' During the course of the inquest, evidence was heard from a nursing witness at Royal Cornwall Hospital who stated: 'During this time the Trust had a significant number of patients waiting ongoing care in the community. In February 2022, on average we had 36 patients waiting discharge home with care package support, 33 patients waiting for ongoing rehabilitation in a community hospital and 51 patients waiting for care home placement or bedded care assessment.' On 21/11/22, my colleague, Assistant Coroner Davies, concluded an inquest into the death of Anthony James REEDMAN, who died on 30 June 2021. His medical cause of death was 1a Cerebrovascular Infarct (Complicated by Post Thrombolysis Bleed) Mr Reedman was 54 at the date of his death, had no relevant medical history, and was described as a fit and active man. He died following a stroke, contributed to by a further complication following the unsuccessful attempt to treat the stroke by way of thrombolysis. The possibility of a successful outcome from the thrombolysis was significantly reduced due to a delay in treatment. Thrombolysis was administered 4.5 hours after the onset of stroke symptoms which is at the extreme edge of the window for that form of treatment. Clinical witnesses stated that with every minute that passes, the prospect of a positive outcome reduces. Furthermore, the risk of bleeding from the thrombolysis increases as time goes on. Mr Reedman suffered further bleeding following thrombolysis. Evidence was heard that the average stroke patient has a 1 in 3 chance of a positive outcome if thrombolysis is given in the first hour after a stroke, that falls to 1 in 25 or 30 at 4.5 hours. This delay in treatment was a direct consequence of ambulance delay. Triaged by South West Ambulance Service (SWAST) as category 2, the target time for the arrival of the ambulance was 18 minutes. The initial categorisation noted the stroke symptoms and the treatment window. The categorisation was later upgraded for the specific purpose of trying to meet that treatment window. The ambulance arrived 2.5 hours following triage. The court heard that at the time of the triage, the ambulance service had sufficient resources for the level of demand, however, there was no available ambulance to respond because ambulances were detained at RCHT due to the inability to offload patients at the Accident & Emergency Department.
4	**CIRCUMSTANCES OF THE DEATH** All of the cases listed above have recurring themes, being long delays in ambulance attendance and/or long delays in admission into the only acute hospital in the coroner area, Royal Cornwall Hospital. It is appropriate to record both that these are only a selection of the inquests of this nature already heard and that there are a number of inquests of a similar nature still to be heard.

Owing to the obvious concerns these inquests have generated, I have endeavoured to speak to key stakeholders to understand the reasons behind the recurring delays.

I have spoken on two occasions to [redacted], the medical director at South West Ambulance Service Trust [SWAST]. At the time he spoke to me, six of the 10 longest ambulance delays were in the south-west. He told me that the difficulties are **NOT** due to a shortage of ambulances or to an unanticipated surge in demand. He is confident the region has sufficient ambulance resources and the Trust's modelling is able to predict accurately likely demands on the service.

His difficulty is that the ambulances are in the wrong place at the wrong time. When they are required for emergency responses, they are parked outside Royal Cornwall Hospital with patients in the back for extended periods. On occasions this summer and autumn, there have been queues of over 20 ambulances outside the Emergency Department and delays have been longer than a paramedic's shift.

I have spoken to the hospital's Medical Director, [redacted], to try and understand the reasons for these delays. At the time I spoke to him, he told me that he had the equivalent of five wards of patients in the hospital who were medically fit to be discharged but for whom either there was no available intermediate/social care bed or a required care package. This appears to be borne out by the evidence I heard during the inquest into the death of Mr Conybeare.

I have spoken to [redacted], the strategic director for care and well-being in Cornwall Council. At the time I spoke to her, she had only been in post for a few weeks. She was, however, able to confirm that one of the Council's main providers of care had closed three homes, being

Trengrouse in Helston;
Mountford in Truro; and
Headlands in Carbis Bay.

This had resulted in the loss of over 110 beds.

The reason she gave for this was that the provider was unable to employ a sufficient workforce to enable the homes to be run at appropriate staffing levels. Indeed, if the three homes in question had not been closed, I understand it would have been inevitable that more of the provider's homes would have needed to have closed.

I understand from [redacted] that the council is seeking to re-procure Trengrouse. I do not have a date by which it is hoped this will happen.

I have also spoken to [redacted], the Chief Executive of the Integrated Care Board. [redacted] was formerly the Chief Executive of Royal Cornwall Hospital. The Board has commissioned research to understand the reasons for the delays that are apparent. I have not seen that research, but I understand the concerns I have identified above are at least part of the findings reached.

[redacted] explained to me the plan the Board has for a provider to build three new homes across the county each offering 90 beds. I do not know the likely timescale for the completion of this project, but a best guess may be something in the order of two years.

Lastly, I have spoken to members of the Local Medical Committee who represent GPs' interests in the county. They have brought to my attention the extreme pressures their members are experiencing [I declare an interest in that my wife is a GP.] I understand that the LMC have shared their concerns with local MPs but they await substantive action being taken.

5	**CORONER'S CONCERNS** My enquiries and the inquests that have been conducted have 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. - While the successful completion of the ICB's building project will go a long way to improving the capacity of intermediate care beds in the county, it is likely to be many months, if not years, before that additional capacity becomes available. My central concern is how the delays that are currently manifest can be mitigated in the intervening months, particularly given the likely increase in demand for ambulances/hospital admissions during the winter months. - While there is an obvious need to discharge medically fit patients from Royal Cornwall Hospital, this has to be done in a controlled and manageable fashion. As set out above, GP representatives have drawn to my attention the extreme pressures primary care is currently under. Without more, it would seem to serve little purpose simply to transfer patients from one part of the system that is struggling to cope to a different part of the system that is equally challenged. - Similarly, it will not benefit patient health to discharge a patient from hospital to a residential home that does not have an appropriate level of staffing. All that will happen is that the patient will inevitably become de-conditioned, their illnesses will worsen and the result will be that they are likely to require re-admission.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 January 2023. 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: The family of Mr Morganti; The family of Mrs Barnes-Weeks; The family of Mr Conybeare The family of Mr Reedman I have also sent it to [redacted] at SWAST, [redacted] at RCHT, [redacted] at Cornwall Council, [redacted] at the ICB and the Cornwall LMC, who may find it useful or of interest. 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 10.11.22**	**SIGNED BY CORONER**