IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Veronica Jenkins
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Acting Chief Executive South East Coast Ambulance Service 4 Gatwick Road Crawley Sussex RH10 9BG Rt. Hon. Steve Barclay Secretary of State for Health and Social Care 39 Victoria Street London SW1H OEU
2	**CORONER** Miss Anna Crawford, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

4	**INQUEST** An inquest into the death of Mrs Jenkins was opened on 7 June 2022. The inquest was resumed and concluded on 30 January 2023. The medical cause of Mrs Jenkins' death was: 1a. Small Bowel Ischaemia 1b. Intra-Abdominal Adhesions due to Previous Surgery The inquest concluded with a short narrative conclusion of 'Recognised Complication of Surgery'.
5	**CIRCUMSTANCES OF THE DEATH** Mrs Jenkins was a 72 year old woman with a diagnosis of bowel cancer for which she underwent a surgical resection in 2016. Thereafter, she had a further procedure to reverse her ileostomy in 2017. In 2022 the cancer spread to her lungs and it was planned for her to commence chemotherapy in May 2022. However, late at night on 10 May 2022 Mrs Jenkins developed sudden onset chest pain and was taken to St. Peter's Hospital, Chertsey, by ambulance. En route to the hospital at 00:39 on 11 May 2022 she suffered a cardiac arrest and was successfully resuscitated at 00:56. She suffered a further cardiac arrest at 01:18 shortly after the ambulance arrived at the hospital and efforts to resuscitate her were not successful and she died at the hospital on 11 May 2022. The cardiac arrest had resulted from Small Bowel Ischaemia which was due to Intra-Abdominal Adhesions, which is a recognized complication of the previous abdominal surgery she had undergone. The court found that there was a delay in the ambulance response for Mrs Jenkins on 10 May 2022 but that the delay did not materially contribute to her death. With respect to the delay, the court heard that the 999 call for an ambulance was made at 23:11 on 10 May 2022 and was correctly triaged at 23:14 as a Category 2 call. Category 2 calls have a mean response time of 18 minutes according to the national framework governing ambulance response times. However, an ambulance did not arrive to Mrs Jenkins' address until 23:47, which is a response time of 33 minutes, and therefore a delay of 15 minutes.

	The court heard evidence from [redacted], Operations Unit Manager at South East Coast Ambulance Service (SECAMBS), that on 10 May 2022 the service was experiencing exceptional demand and the response times for all categories of 999 calls were experiencing significant delays with an increased potential for patient safety and care to be compromised. [redacted] gave evidence that the delays were due to a deficit in the amount of operational hours that SECAMBS was able to provide on 10 May 2022. The overall required operational hours across the region were 9,652 and on 10 May 2022 only 9,064 were provided, which is a deficit of -6.1%. With respect to the Chertsey area particularly, the required operational hours were 822.00 and only 751.75 were provided, which is a deficit of -8.5%. [redacted] gave evidence that the deficit was due to two factors – 1. A lack of availability of staff due to a combination of sickness, covid related absence and annual leave; and 2. Handover delays at hospitals leading to a loss of 191.04 operational hours across the region on 10 May 2022. Having heard the evidence, the court was not reassured that these factors would not reoccur in the future, as such giving rise to the risk of future deaths.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: There is a risk of a future reoccurrence of the situation which arose on 10 May 2022, namely a deficit in operational hours provided by SECAMBS leading to delayed response times compromising patient safety. This risk is due firstly to a lack of available staff to provide the required operational hours and secondly to handover delays at hospitals across the region. The first issue is addressed to the Chief Executive of SECAMBS and the second issue is addressed to the Secretary of State for Health and Social Care.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mrs Jenkins' family
10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 31st day of March 2023**