*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms V Atkins, MP, Secretary of State for Health and 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** Over the past week, I have concluded the following three inquests. John Charles Seagrove Mr Seagrove was an 88-year-old man who died in Royal Cornwall Hospital on 9/7/22. His medical cause of death was found to have been: 1a) Aspiration pneumonia; 1b) Ischaemic stroke. On 22 June 2022, he developed symptoms consistent with a stroke. An ambulance was called at 23:21 with the call being classed as a Category 2 disposal meaning an ambulance should attend within an average of 18 minutes and 90% of similar disposals should be actioned within 40 minutes. Owing to operational pressures, an ambulance arrived at 07:20 the next morning. Mr Seagrove arrived at Royal Cornwall Hospital at 08:09 and was handed over to staff at 10:15 where the handover should be completed within 15 minutes. Mr Seagrove was found to have suffered an ischaemic stroke. He arrived outside a 4.5 hour window for thrombolysis and according to evidence at the inquest given from [redacted], stroke consultant, lost the opportunity to benefit from the reduction in the severity of the stroke such treatment can provide. He deteriorated over the next few weeks and died in the hospital on 9/7/22.

I recorded a Conclusion of Natural Causes.

Pauline Mary Humphris

Mrs Humphris was an 88-year-old lady who lived alone in an isolated location. She had become increasingly frail and immobile to the point she was essentially housebound. In the last months of 2022, she developed a wound to her leg that became infected. This was treated with antibiotics.

Over the New Year, Mrs Humphris deteriorated. An ambulance was called at 18:37 on 1 January 2023 but did not arrive with Mrs Humphris until 07:28 the following morning. There was then a further delay admitting Mrs Humphris into hospital. She continued to deteriorate and died in Royal Cornwall Hospital on 2/1/23.

The medical cause of death was determined to be:
1a) Hypertensive heart disease;
II) Cellulitis.

[redacted], acute physician, stated: “I was asked to comment on whether the ambulance delay had played a role in her death. She was very unwell by the time she reached hospital with sepsis, pneumonia and cellulitis and the hypoglycaemia was a very bad prognostic sign. The earlier that sepsis is treated with antibiotics the better the outcome and the higher the chance that she would have survived. I cannot say she would have definitely survived if she would have had her treatment earlier but the delay in giving antibiotics in sepsis is a major factor in a poor outcome. The chance of survival would have improved significantly with earlier antibiotics.”

[redacted], her friend and executor, said: “Personally, I believe that Paula was entirely let down by a system obviously at breaking point. Whilst one can obviously sympathise with the pressures that doctors, nurses, ambulance staff and 999 operators are under it is simply inconceivable to me that the system has deteriorated to such an extent that an ambulance can take 16 hours to arrive after the first call to the emergency services made by me at 6:30 PM on the previous day.”

I concluded her death was due to Natural Causes. I further found that a delay in the arrival of an ambulance due, in part, to delays admitting patients into hospital, may have contributed to the outcome.

Patricia Joan Steggles

On 30/12/21, Mrs Steggles started to complain of pain in her abdomen and vomiting. An ambulance was called. A paramedic attended who examined her and ruled out a cardiac cause. He felt a stomach bug was likely.

In the early hours of 31/12/21, Mrs Steggles called the out of hours

	service with worsening pain. A doctor attended who felt she had an acute abdomen. He called an ambulance at 02:41. Mrs Steggles did not arrive at the Emergency Dept until 11:52. She was triaged and seen by a junior doctor in the back of an ambulance. A CT scan was ordered at 15:12 and at 16:20 it was recorded in the notes that Mrs Steggles had a sub-hepatic collection likely due to a perforated gallbladder. She was prescribed IV antibiotics and referred to the surgeons. She was reviewed four hours later when a decision was made to treat her by way of interventional radiology. An on-call service was not available out of hours and so it was felt Mrs Steggles could be treated the following day. She deteriorated and died on the morning of 1/1/22 in Royal Cornwall Hospital. The inquest heard from [redacted], an Emergency Medicine consultant. He said that with the department as crowded as it was, it was not possible to deliver an optimum service. I asked him whether the situation had improved since this incident. He said there had been an improvement over the summer but over the last 2-3 weeks there had been times when there were 15-20 ambulances waiting outside the emergency department again. He said that when he chose a career in Emergency Medicine, he never envisaged looking after patients in the back of ambulances. The inquest also heard from [redacted]. He is a consultant upper GI surgeon and the speciality lead for surgery within Royal Cornwall Hospital. [redacted] agreed with [redacted], an expert instructed to assist the inquest, that if Mrs Steggles had been brought to hospital earlier, then it was more likely than not she would have survived. I recorded a Conclusion of a death from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The relevant circumstances are set out above. All three deaths feature delays first in emergency ambulance response times and secondly, handing over the patient from the ambulance crew to hospital staff. I want to be clear that these three deaths are not isolated cases. They are just an illustration of the sorts of cases this area has dealt with regularly over the last two years or so. I understand my colleague, Assistant Coroner Davies, also feels his duties under PFD Regulations are engaged and he will be writing to you in similar terms in relation to inquests he has conducted.
5	**CORONER'S CONCERNS** The circumstances described above are now longstanding. I wrote a

	Preventing Future Deaths report to your predecessor just over a year ago setting out details of four deaths that had arisen in similar circumstances. During the course of these inquests, the evidence has 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. It was acknowledged in the evidence that matters had improved over the summer this year. What is of concern, however, is that these gains have not been maintained and the situation has now worsened with 15-20 ambulances waiting outside the ED on occasions over the last three weeks. I have spoken to the Medical Director at RCHT, [redacted], and he has confirmed that is the current position. This concern is compounded by the recognition that we are yet to experience the additional pressures that winter will bring. Additionally, I am now hearing evidence at inquest of 'burn-out' among paramedics, nurses and doctors. At the inquest into the death of Mrs Steggles, I was advised that the hospital is now finding it difficult to recruit to vacant positions.
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 set out in my PFD last year my understanding of the reasons for the difficulties that are continuing in the Cornwall & Isles of Scilly coroner area. I do not believe those reasons will have changed significantly. The challenges are systemic in nature. They are too big for a single doctor, nurse or paramedic to fix. They are too big for either the hospital trust or the ambulance trust to fix on their own. It is for you and your department to take the action that is required to resolve the issues and to prevent future patients in the area from dying avoidable deaths. It is not for me as coroner to make recommendations on how you do that and so I leave that to you.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 January 2024. 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 John Seagrove; - The family of Pauline Humphris; - The family of Patricia Steggles; - Royal Cornwall Hospital Trust ([redacted], Medical Director); - South West Ambulance Service Trust ([redacted], Medical Director); - [redacted] – Chief Executive, Integrated Care Board; - [redacted] – Chief Executive, Cornwall Council 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]** **23/11/23**