IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF KENNETH HEARD

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ms Victoria Atkins MP, Secretary of State for Health & Social Care**
1	**CORONER** I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & 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 12 July 2022 I commenced an investigation into the death of 79-year-old Kenneth Heard. The investigation concluded at the end of the inquest on 31 October 2023. The medical cause of death was found as follows: *1a Cardiac Arrest* *1b ST Elevation Myocardial Infarction* *II Hypertension, Hypercholesterolemia, Psoriasis* The four statutory questions - who, when, where and how – were answered as follows:

	Kenneth HEARD died on 11 July 2022 at Royal Cornwall Hospital Truro from an untreated heart attack leading to cardiac arrest before surgical procedures could be commenced which would have significantly increased Kenneth's prospect of survival. The heart attack was untreated due to an eight-hour delay in the arrival of the ambulance, it being more likely than not that Kenneth would have survived but for that delay. My conclusion as to Kenneth's death was as follows *Kenneth Heard died from a cardiac arrest following a heart attack which was untreated due to an ambulance delay.*
4	**CIRCUMSTANCES OF THE DEATH** On 10 July 2022 Kenneth had a major heart attack, symptoms starting from 2pm that day. He had no relevant medical history excepting a report of chest pains three weeks before his death. Kenneth's wife, [redacted], made a 999 call at 16:55 hrs on 10th July 2022. The call was triaged as category 2 priority. The national target set by the Department of Health is to attend Category 2 incidents within 40 minutes on at least 90% of occasions, with an average response of 18 minutes. The ambulance arrived the following day, 11 July 2022 at 01:05:59hrs, giving a response time of 8 hours, 10 minutes from the original 999 call. Treliske hospital (Royal Cornwall Hospital Trust in Truro), were pre-warned about Kenneth's condition and the surgical team were in theatre ready to perform an operation to insert a stent. However, Kenneth suffered a cardiac arrest on arrival at Treliske. The surgical team were summoned to assist with resuscitation. Medical teams attempted resuscitation for 47 minutes, but this was unsuccessful. On the basis of evidence from the cardiologist, the court found that early treatment within 2 hours of a heart attack leads to significantly improved chances of survival. Surgery within 2 hours, leads to a 95 % survival rate. The court found that on a balance of probabilities it is more likely than not that Kenneth would have survived but for that ambulance delay.
	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. –

(1) The ambulance delay in Kenneth's case, on 10 to 11 July 2022, was due to the demand on the service and delays in the patient handover process at the two main hospitals servicing Cornwall: Treliske (Royal Cornwall Hospital Trust in Truro) and Derriford (University Hospitals Plymouth Trust).

(2) The target for hospital staff to take responsibility for the care of patients from ambulance crew is within 15 minutes of the ambulance arriving at an Emergency Department.

(3) On 10 July 2022 there were over 403 hours of ambulance time lost at Treliske Hospital with the average handover taking seven hours and 34 minutes per patient. At Derriford Hospital, there were over 201 hours lost, with the average handover taking three hours and 28 minutes.

(4) Evidence heard at Kenneth's Inquest indicates that there is a strong relationship between the hours lost due to handover delays and the response times being delivered by SWAST. Data shows that as the time lost to handover delays has increased, the response times have increased at a similar rate. In Kenneth's case this relationship between response and handover is clearly revealed. The ambulance response time to Kenneth was eight hours and 10 minutes. The concurrent average handover delays being experienced at Treliske was seven hours and 34 minutes per patient.

(5) The court heard evidence of mitigating measures having been introduced in late 2022 and early 2023 to seek to address and reduce the impact of response and handover delays.

(6) This included the provision of pressure sore equipment to paramedic crews. Evidence was heard from SWAST that since the introduction of these mitigating measures some patients have still spent over 12 hours in an ambulance awaiting admission to hospital. This is the reason for the provision of pressure sore equipment to ambulance crews.

(7) Notwithstanding these mitigating measures, concern arises from present circumstances, in relation to handover delays across the region covered by SWAST and specifically at the two hospitals most commonly used by patients from Cornwall, Derriford Hospital in Plymouth and Treliske Hospital in Truro.

(8) The most recent data available is for August 2023, in which month across the region covered by SWAST the hospitals suffering the longest

ambulance delays were Treliske, Derriford and Gloucester. The data indicated that operational resource hours lost due to handover delays in excess of 15 minutes was as follows:

5,107 hours lost at Derriford Hospital,
Average Handover Time per Incident (Hrs:Mins:Sec) 2:04:36

2,449 hours lost at Treliske Hospital,
Average Handover Time per Incident (Hrs:Mins:Sec) 1:01:13

(9) Response times during June, July and August 2023 were heavily impacted by the handover delay pressures. The best response times were delivered on the weeks with the lowest hours lost to handover delays. The data for time lost due to handover delays at Derriford and RCHT in June, July and August 2023 are set out below.

Operational Resource Hours Lost to Handover Delays in Excess of 15 Minutes	Time Lost in June 2023	Time Lost in July 2023	Time Lost in August 2023
Derriford Hospital	4714:17	3436:41	5107:36
Treliske Hospital	2833:15	2386:23	2449:47

(10) By comparison the court was informed that before the pandemic the average number of hours lost due to handover delays was approximately 4,000 hours per month across the whole of the SWAST region. During 2022 the average number of hours lost due to handover delays was approximately 25,000 hours per month across the whole of SWAST. The worst month of last year was December 2022. The number of hours lost due to handover delays in that month across the whole of SWAST region, was approximately 35,000.

(11) The court heard evidence that there are future circumstances creating a concern of a risk to life, namely the seasonal nature of demands on SWAST. The winter months are likely to see an increase in demand for ambulance services and for hospital beds. December 2022

was the most demanding month of last year and featured the longest delays in response and handover. December 2023 is likely to be the most demanding month of this year.

(12) The root cause for ambulance delays was found to be the lack of social care provision in Cornwall, whether care packages or beds in care homes. It was acknowledged and accepted by NHS representatives at Inquest that Treliske and Derriford are unable to discharge otherwise medically fit patients due to the lack of social care provision. This means that wards are accommodating patients who would otherwise be discharged. The hospital wards being full beyond capacity, means that emergency departments are unable to move patients out of emergency beds into the wards. This means in turn that the emergency department is full and unable to receive patients from ambulances. This leads to the handover delays, and consequently response delays, documented in the data set out above.

(13) HM Senior Coroner for Cornwall, Mr Andrew Cox has previously issued an R28 PFD Report regarding ambulance delays, in November 2022, addressed to the Secretary of State for Health. That report raised the exact same concerns as those set out above. This included the fact that at the date of the Inquest there were the equivalent of five wards of patients in Treliske who were medically fit to be discharged but for whom either there was no available intermediate/social care bed or a required care package.

(14) Since that report this court has heard numerous cases involving ambulance delays in 2022, some of which have found the delays to be contributory to the cause of death.

(15) Shortly after Kenneth's Inquest, I presided over the Inquest of 93 year-old Peggy Watters which raised identical concerns regarding ambulance delays on admission to Treliske emergency department. The Inquest was conducted and concluded on 9 November 2023. Peggy died on 11 March 2023 from complications following a fractured neck of femur sustained in a fall at her home address on 17 February 2023 against a background of frailty and multiple physical health conditions. The evidence revealed a 20-hour ambulance delay on 17 to 18 February 2023. This delay followed the first 999 call made by the family after Peggy's fall in which she sustained her fracture. This included a response delay of 12 hours, 52 minutes, and a handover delay of 7 hours, 26 minutes. Although the court found the ambulance delay to be minimally contributory to Peggy's death, the court did hear evidence of the significant pain and anxiety suffered by Peggy whilst waiting for the ambulance. The court also heard evidence of the concern regarding present and future circumstances leading to the risks of future deaths as set out above.

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 18 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 Kenneth Heard, SWAST and Treliske hospital. I have also sent it to Derriford hospital and the family of Peggy Watters, 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	**23 November 2023** **Guy Davies**