IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF PATRICIA ANNE VAN DER EYKEN

	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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 29 September 2023 I commenced an investigation into the death of Patricia Anne Van Der Eyken. The investigation concluded at the end of the inquest on 11 March 2024. The medical cause of death was found to be as follows: *1a Malignant Acute Cardiac Arrhythmia* *1b Coronary Artery and Systemic Atherosclerosis* The four questions - who, when, where and how – were answered as follows: *Patricia Anne VAN DER EYKEN died on 13 September 2023 at Rivercourt 5 East Bridge Chacewater Truro Cornwall from cardiac arrhythmia due to atherosclerosis following an ambulance delay which more likely than not contributed to Patricia's death by preventing the administration of life saving treatment.* The conclusion of the Inquest was that Patricia died from an (untreated) heart attack following an ambulance delay which likely contributed to Patricia's death by preventing the administration of life saving treatment.

4	**CIRCUMSTANCES OF THE DEATH** Patricia was 93 years old at the date of her death. Her medical history indicated that Patricia was fit and well for her age. In the early hours of 13 September 2023 Patricia called 999 reporting symptoms of a heart attack, namely a sharp pain in her chest, and down her left arm. Following the 999 call, South West Ambulance Service Trust (SWAST) determined a Category 2 response requirement. Category 2 identifies potentially serious conditions that may require rapid assessment, urgent on-scene intervention and/or urgent transport. The national response time as set by the Department of Health is to attend Category 2 incidents within an average response time of 18 minutes, and at least 90% of incidents within 40 minutes. The ambulance arrived on scene after a delay of two hours and 37 minutes from the time of the '999' call by Patricia. Patricia was found deceased by the ambulance crew. The court heard evidence of the post-mortem which indicated that Patricia died following cardiac arrhythmia due to atherosclerosis. The court heard evidence from a medical examiner regarding Patricia's death. The medical examiner stated that the original description of chest pain radiating to the left arm is strongly suggestive of myocardial ischaemia. The court found that there are a range of appropriate treatments for conditions such as those reported by Patricia. This included the availability of treatment to prevent the subsequent arrhythmia that led to Patricia's death. The court found that if Patricia had been admitted to hospital promptly, that it is likely that appropriate treatment would have prevented Patricia's death. The court found that the categorisation of the call by ambulance services was appropriate. The court found that the delay was not caused by any individual failing but was attributable to a systemic failure discussed in the concerns set out below.
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. – 1. Patricia's death followed an ambulance delay, attributable to a systemic failure, which is likely to have contributed to Patricia's death by preventing lifesaving treatment. 2. The systemic failure was found to be due to issues within healthcare services external to SWAST and notwithstanding increases in SWAST staff numbers and ambulance numbers. 3. Performance data published by SWAST and considered at Inquest, reveals that in 2023 the two hospitals (in the SWAST region) most impacted by ambulance delays are Royal Cornwall Hospital Truro (Treliske) & University Hospital Trust Plymouth (Derriford). These are the two hospitals servicing patients in Cornwall. 4. The court heard that at the time of the ambulance delay that contributed to Patricia's death, SWAST had 130% resources available to meet anticipated

demand. The increased resources were not able to overcome the systemic failures impacting SWAST. Between 02:00 and 03:00 hours on 13 September 2023, SWAST had 20 ambulances queuing at Treliske and Derriford.

5. The court considered the findings in the SWAST Patient Safety Incident Investigation Report & an associated investigation conducted by the Healthcare Services Safety Investigation Branch (HSSIB). These investigations found that…

> *'…there is a direct link between patients waiting in the hospital for discharge to social care, and patients being cared for inside ambulances and Emergency Departments.'*

6. In other words, the investigations found that there is a direct link between failings in social care provision and ambulance delays. The failings in social care provision were found to have a knock-on effect through healthcare services. It was found that at times hospitals were unable to transfer patients from hospital wards into the community when clinically indicated. This is because of the difficulty in securing sufficient domiciliary or residential care, as and when required. This leads to delayed discharges from hospital of patients deemed medically fit for discharge.

7. Furthermore, it was found that delayed discharge can lead to an increase in rehabilitation and care needs. This is an effect of delayed discharge leading to further impact upon hospital capacity.

8. It was found that the build-up of patients in wards (patients who are medically fit for discharge) means that the hospitals are, at times, unable to transfer patients from the emergency department to hospital wards when clinically indicated. This in turn leads to a build up of patients in emergency departments. This leads to handover delays between ambulance and hospital, namely ambulance crews being unable to transfer patients from ambulances into the emergency department. It was found that there is a strong correlation between ambulance handover delays and increasing ambulance response times. The report stated:

> *''It is as simple as the longer a patient is waiting in an ambulance outside a hospital, the longer the next patient will wait for an ambulance''.*

9. The investigation report states

> *'…SWAST is experiencing by far the highest levels of handover delays seen in the Trust's history. Handover delays result in multiple ambulance resources being held at hospitals for extended periods, thereby limiting the number of resources on the road to respond to waiting incidents. With fewer resources on the road, the response times to patients inevitably increases…*
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> *….The impact of the delays …is devastating¸ most significant¸ and most immediately evident to patients and their families and carers. Less evident is the secondary¸ detrimental effect these delays can bring to the service as a whole. This investigation found that delays are having an additional profound impact on staff morale and their mental wellbeing.''*

10. The court considered SWAST performance data for 2023 in connection with handover delays between ambulances and hospitals. There is a target for crews to handover the care of their patients within 15 minutes of arriving at an Emergency Department. Anything above this constitutes a delay which impacts on the availability of resources. The data revealed that in September 2023, handover delays (in excess of 15 minutes), cost the ambulance service 2,981 hours at Treliske. This is equivalent to 271 ambulance crew shifts. At Derriford in the same month, handover delays (in excess of 15 minutes) cost the ambulance service

	6,359 hours, which is equivalent to 581 ambulance crew shifts. 11. The court considered data for 2023 showing total operational resource hours lost to handover delays in excess of 15 minutes. The total lost by SWAST at Treliske was 35,583 hours. At Derriford the total lost in 2023 was 53,080 hours. 12. The court noted that two reports have been issued by this court in November 2023 addressed to the Health Secretary raised the same concerns regarding ambulance delays. A response to those reports is still awaited.
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 20 May 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 and SWAST. I have also sent a copy to Royal Cornwall Hospital Truro ([redacted]), University Hospital Trust Plymouth ([redacted] and Cornwall Council 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	**25 March 2024** **Guy Davies, HM Assistant Coroner**