IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF ROBERT ANDREW PROWSE

	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 25 September 2023 I commenced an investigation into the death of Robert Andrew PROWSE. The investigation concluded at the end of the inquest on 18 March 2024. The medical cause of death was found to be as follows: *1a. Urosepsis* *2 Frailty of Old Age* The four questions - who, when, where and how – were answered as follows: *Robert Andrew PROWSE died on 19 September 2023 at Royal Cornwall Hospital Truro Cornwall from sepsis following an ambulance delay, attributable to a systemic failure, which is likely to have contributed to Robert's death by preventing lifesaving treatment.* The conclusion of the inquest was that Robert died from sepsis contributed to by an ambulance delay, attributable to a systemic failure, which likely prevented lifesaving treatment.

4	**CIRCUMSTANCES OF THE DEATH** Robert was 86 years old at the date of his death. His medical history included a diagnosis of dementia. In the early hours of 19 September 2023 Robert's neighbour called 999 on his behalf advising that Robert had been found breathing but not conscious, and it looked like he had had a seizure. 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 three hours and 47 minutes from the time of the original 999 call. The ambulance arrived at Royal Cornwall Hospital Truro (Treliske) but it was not possible to transfer Robert to the emergency department (ED) due to the lack of available space. The court heard evidence of crowding within ED which included patients being placed in corridors. Robert was instead taken from the ambulance to a triage centre adjacent to Treliske ED. The triage centre is known as the Rapid Assessment and Treatment Centre. There it was noted that Robert displayed evidence of sepsis but it was determined that his condition was not immediately life threatening. Robert was given fluids but not antibiotics and then returned to the ambulance parked outside ED. Robert remained in the ambulance attended by the paramedic crew until later transfer to ED at 11:05 hours. The delay in handover between ambulance and Treliske ED was one hour, 25 minutes. There is a target for crews to handover the care of their patients within 15 minutes of arriving at an Emergency Department. Robert was then subject to tests and sepsis was identified. Robert was found deceased at 13:00 hours. Antibiotics had been prescribed but Robert died before they could be administered. The court heard evidence from [redacted] that the ambulance delay, including response delay and handover delay, likely contributed to Robert's death. This is because earlier treatment of sepsis is likely to avoided Robert's death. [redacted] stated that early treatment of sepsis by way of oxygen, antibiotics and fluids, saves lives and improves outcomes. In Robert's case earlier treatment is likely to have made a difference to the outcome. 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. Robert's death followed an ambulance delay, attributable to a systemic failure, which is likely to have contributed to Robert'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 Robert's death, SWAST had 136% resources available to meet anticipated demand. The increased resources were not able to overcome the systemic failures impacting SWAST.

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.

9. The court heard evidence that Treliske have established a triage centre in the car park, known as the Rapid Assessment and Treatment Centre. The primary purpose of triage is to identify those patients in immediately life-threatening condition. The triage centre is an attempt to mitigate the risks due to ambulance delay and overcrowding in ED. [redacted] stated that the vast majority of patients are now seen in the car park, inside ambulances or in the triage centre, rather than in ED.

10. The court heard evidence of crowding at Treliske ED with patients being accommodated in the corridors. Evidence was heard from [redacted] regarding a scientific study by Royal College of Emergency Medicine (published in the Emergency Medicine Journal). This study discussed the adverse impact of crowding in ED. The study calculated the estimated number of excess deaths occurring across the United Kingdom associated with crowding and extremely long waiting times. The study showed that for every 72 patients waiting between eight-

	and 12-hours from their time of arrival in the Emergency Department there is one patient death. 11. The court heard evidence that in September 2023 patients had spent a total of 14,327 hours in Treliske ED when it was clinically appropriate for these patients to be discharged or moved to a ward. This period of time is equivalent to closing 19 cubicles in Treliske ED for a whole month. Treliske ED has 26 cubicles. 12. The build-up of patients in the emergency department 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 investigation 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''.* 13. 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…* *….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.''* 14. 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. 15. 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. 16. 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 [AND/OR your organisation] 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, SWAST and Royal Cornwall Hospital Truro (Treliske). I have also sent a copy to University Hospital Trust Plymouth (Derriford), [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**