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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], 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** On 29/7/24, I concluded the inquest into the death of Colonel John Frederick Codd (Bill) who died on 16/1/24 at the age of 88. I recorded the cause of death as: 1a) Massive rectus sheath haematoma and severe coronary artery atherosclerosis; II) Essential hypertension. I recorded a Narrative conclusion that Colonel Codd died from an Accident. There was a delay in the arrival of an ambulance and a further delay in admitting Colonel Codd from the ambulance into the Emergency Department. It is probable that an earlier admission into ED would have resulted in an earlier CT scan that would have revealed the haematoma that developed. It is possible that a blood transfusion could have been arranged that may have avoided the outcome.
4	**CIRCUMSTANCES OF THE DEATH** On 16/1/24, Colonel Codd fell over while exiting a taxi that had collected him after an appointment with his GP. An ambulance was called at 12:31 and the initial disposition was for a Category 3 response requiring 90% of attendances within 2 hours and an average of 60 minutes. The ambulance arrived at 14:49, left the scene at 15:46 and arrived at Royal Cornwall Hospital at 16:30. Although there was a delay in ambulance attendance, I felt this was relatively modest and unlikely to have been a contributory factor in the death.

	National guidance requires a handover to hospital staff within 15 minutes. Unfortunately, the hospital was full and Colonel Codd remained in an ambulance outside the hospital until he was brought into a bed in the Majors 2 part of the ED at 21:11, approximately 4 hours and 40 minutes after arrival. At 22:10, Colonel Codd was found collapsed in cardiac arrest. He could not be resuscitated. At inquest, I heard from [redacted], one of the ED consultants at the hospital. I accepted his evidence that had there been a timely admission; - An x-ray to confirm/exclude a hip fracture would have been conducted earlier; - A CT scan ordered to elucidate the findings of the x-ray would then have been ordered earlier (the CT was not conducted); - It was probable the CT scan would have revealed the haematoma from which Colonel Codd died; - It was possible that a blood transfusion could have been organised that would have avoided the death.
5	**CORONER'S CONCERNS** 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. 1) At the time of these events, (January 2024) monthly crowding analysis, that is the total amount of time patients spent waiting for beds or transport after a decision 'ready to discharge' from ED was made totalled 23,875 hours, the equivalent of closing 32 cubicles to ED for 24 hours/day for a whole month. 2) Last month, in June 2024, the situation had improved but still totalled 16,245 hours of lost time, the equivalent of closing 22 cubicles for an entire month. [redacted] was clear in his evidence that significant pressures remained on the ED at Royal Cornwall Hospital which had the potential to affect future patient care.
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. It is not for a coroner to make recommendations and so I leave you to consider how best to help ease the pressures that continue to be felt in the ED at Royal Cornwall Hospital.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 September. 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: - [redacted], daughter - [redacted], granddaughter - Royal Cornwall Hospital (via its solicitors) 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]** **29/7/24** **[SIGNED BY CORONER]** [redacted]