REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF DENNIS RICHARD HARRY

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Rt Hon Wes Streeting MP, Secretary of State for Health and 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 13 February 2023 I commenced an investigation into the death of Dennis Richard Harry. The investigation concluded at the end of the inquest on 12 September 2024. The medical cause of death was found as follows: *1a. Hypertensive heart disease and SARS-CoV-2 infection* *(1a being the disease or conditions directly leading to death)* The four statutory questions - who, when, where and how – were answered as follows: *Dennis Richard Harry died on 10 January 2023 at Royal Cornwall Hospital Truro from heart disease and Covid-19 infection following a grossly excessive ambulance delay attributable to a systemic failure related to the whole system of health and social care.* *There was a response delay of 15 hours and 35 minutes from the original 999 call on a category 2 priority requirement*, and then a delay in the handover between the ambulance and the hospital of three hours and 14 minutes.* *The total ambulance delay of 18 hours and 50 minutes led to a significant delay in the commencement of treatment.* *Dennis subsequently made a partial recovery and was being considered for discharge when he contracted an infection which delayed his discharge and then contracted covid 19 which caused his death.* *Were it not for the significant delays in treatment it is possible that Dennis may*

	have had a speedier recovery and been discharged before contracting covid 19, or alternatively Dennis might have acquired greater resilience to withstand the covid 19 infection which led to his death. *[*Category 2 identifies those patients who have a potentially serious condition that may require rapid assessment, urgent on scene clinical intervention and/or urgent transport to hospital.]* The narrative conclusion of the inquest was as follows: *Dennis died from Covid 19 and heart disease following a grossly excessive ambulance delay of 18 hour and 50 minutes, this delay being attributable to a systemic failure related to the whole system of health and social care, which was possibly causative of death.*
4	**CIRCUMSTANCES OF THE DEATH** 1. The findings of fact on how Dennis died are set out above in the answers to the four statutory questions. **Systemic failure and Dennis' death** 2. The court made findings of fact upon the wider circumstances, namely the systemic failure that was possibly causative of Dennis' death. 3. On the day the ambulance call was made (20th December 2022) there were considerable ambulance delays. At approximately the time the ambulance call was made, 15:42 hours, there were between 13 and 18 ambulances waiting outside the Emergency Department (ED) at Royal Cornwall Hospital (RCHT). 4. At approximately 08:00 on 21st December when Dennis arrived at ED there were 56 patients in the ED and 11 ambulances waiting outside the ED. The ED is built to house 44 patients. 5. In December 2022, the total amount of time waiting for beds or transport after decisions to discharge from ED totalled 20,144 hours which is the equivalent of 27 cubicles being closed to ED. This amounts to more than half the available space in ED taken throughout December 2022 by patients waiting for beds to become available on acute wards or for discharge for alternative care arrangements. 6. The court found that the hospital regularly failed to meet the 4-hour target for moving patients out of ED at the time of Dennis' death and since. It was noted that there is a recent major study which shows that the standardised mortality rate starts to rise from 5 hours after the patient's time of arrival at the ED and they concluded that after 6–8 hours, there is one extra death for every 82 patients delayed. 7. The court found insufficient bed availability on acute wards which was attributed to an increase in patients with no reason to reside (NCTR), these being patients who are medically optimised but cannot be discharged due to lack of onward care support. 8. Approximately 80% of NCTR patients are of that status for external reasons beyond the control of RCHT. The main causes of external NCTR numbers were found to be as follows: • Social care provision (whether commissioned by social services or NHS) namely packages of care in the community, beds in nursing homes or residential care homes • NHS primary healthcare support for discharge (in the home) • NHS community hospital provision 9. On the day of Dennis' 999 call 20 December 2022 the externally delayed NCTR was approximately 120 patients. This is over 20% of RCHT bed capacity. 10. The court found significant correlation between delayed discharges, handover delays and delays in response times. On this basis, the court found there was a direct connection between the ambulance delay experienced by Dennis and

inadequate social care provision, community hospital provision and primary healthcare support leading to delayed discharges from hospital.

11. The connection between delayed discharges and ambulance delays and the associated risks has been referred to in reports from Southwest Ambulance Service Trust (SWAST) and the Health Services Safety Investigations Body (HSSIB). The court found that the state knew or ought to know of the risks.

Current circumstances of systemic failure

12. The findings of fact upon current circumstances in relation to the systemic failure were as follows.
13. There was found to be a direct connection between current ambulance delays and inadequate social care provision, community hospital provision and primary healthcare support on discharge. This is because inadequacies in those services lead to delayed discharges from hospital which lead to shortages of acute beds, impeded patient flow, crowding in ED and the inability of ambulances to handover patients to ED.
14. Significant average handover delays at RCHT were recorded for every month of 2024. This is a picture reflected across the SW and indeed nationally.
15. The average handover delays conceal spikes such as that which led to the long delay as in this case. Such long delays increase the risk of mortality.
16. There are continuing delays of patients from ED which is evidenced by the ongoing failure to regularly meet the 4-hour standard. These delays increase the risk of mortality.
17. Over the last year up to 16% of patients in RCHT have been of external NCTR status, patients who meet the criteria for discharge but cannot be discharged for reasons external to RCHT.
18. The court found that if the external NCTR numbers could be reduced, this would significantly address current issues of ambulance delays, ED crowding, and the shortage of acute beds.
19. The main drivers of external NCTR patients are inadequate social care provision, community hospital provision and primary healthcare support on discharge.
20. Approximately 10% of social care posts in Cornwall are currently vacant notwithstanding Cornwall Council securing the agreement of social care providers to pay the living wage. This reflects the national picture of 165,000 vacant social care posts.
21. The NHS and Cornwall Council generally do not employ social care staff and rely upon social care providers.
22. In connection with care homes there are no Cornwall Council owned care homes, the Council does not directly run any homes and does not plan to build any new care homes.
23. The Council does have a ‘’…development framework which will support local and national developers to build new care homes in Cornwall.’’
24. The extent of the obligation on local authorities is set out in the Care Act s5

    A local authority must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring [inter alia] …. a variety of high quality services to choose from…

25. The NHS does not carry responsibility for the recruitment and retention of social care staff or any broad obligation to promote the social care market.
26. The organisations immediately required to deal with ambulance delays are ambulance trusts and acute hospitals, In Cornwall that is SWAST and RCHT. These organisations do not have control over the services primarily responsible for ambulance delays, namely social care provision, primary healthcare provision and community hospital provision. They are unable to influence the whole-system and therefore carry risks that they cannot wholly mitigate or manage.
27. The court noted the HSSIB report which states that delayed discharges (and consequent ambulance delays) are a national issue which is attributed to a whole system failure of health and social care. The court noted the HSSIB investigation’s first safety recommendation is an urgent ‘whole system’ response to reduce patient harm.

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) **There is a direct connection between the risk of excessive ambulance delays and inadequate social care provision, community hospital provision and primary healthcare support for discharges in Cornwall.** This is because the inadequacies in these services lead to delayed discharges causing crowding in ED and handover delays. This creates a risk of future systemic failures causing excessive ambulance delays. 2) **There is no single organisation with responsibility to ensure that the provision of social care is sufficient to avoid delayed discharges leading to ambulance delays**. The obligation upon local authorities such as Cornwall Council is limited to a requirement to promote the market. 3) **There is an absence of any overarching organisation with responsibility for patient safety risk from ambulance delays.** The organisations immediately required to deal with ambulance delays do not have control over the services primarily responsible for the delays.
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 25 November 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: Dennis' family, RCHT, SWAST, Cornwall Council, NHS Integrated Care Board for Cornwall, I have also sent it to other bereaved families who have experienced ambulance delays and 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	**22 September 2024** **Guy Davies**