REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF KEVIN GEORGE WOODS

	THIS REPORT IS BEING SENT TO: [redacted], **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.
3	**INVESTIGATION and INQUEST** On 19 January 2024 I commenced an investigation into the death of 64-year-old Kevin Woods. The investigation concluded at the end of the inquest on 30 September 2024. The medical cause of death was found as follows: *1a. Hypertensive heart disease* The four questions - who, when, where and how – were answered as follows: *Kevin George WOODS died on 17 January 2024 at [redacted] from complications of an undiagnosed heart condition following an ambulance delay which denied Kevin the opportunity of potentially lifesaving treatment.* *Kevin's family made a 999-call requesting an ambulance at 22:24 hours on 16 January 2024, at which time Kevin was exhibiting clear symptoms of a heart attack. The ambulance service allocated Kevin a category 2 priority but there were no ambulances available on that category.* *Kevin went into cardiac arrest at 02:33 hours on 17 January 2024 and subsequently became unresponsive. The ambulance service re-categorised the call as category 1 and despatched an ambulance.* *A Paramedic Support Vehicle arrived at 02:44 hrs on 17 January 2024 whilst the family were giving Kevin CPR. The paramedics continued CPR but were unable to save Kevin's life. Kevin was pronounced deceased at the scene at 03:31 hrs that day.* *There was a response delay of 4 hours and 16 minutes from the original category 2 priority decision to the arrival of the paramedic support vehicle.*

	Kevin's heart condition was possibly treatable, and the ambulance delay denied him the opportunity of potentially lifesaving treatment. The ambulance delay was attributable to a systemic failure related to the whole system of health and social care. The narrative conclusion of the Inquest was as follows: *Kevin died from an undiagnosed and possibly treatable heart condition, following an ambulance delay attributable to a systemic failure related to the whole system of health and social care. The ambulance delay was possibly causative of death in that it denied Kevin potentially lifesaving treatment.*
4	**CIRCUMSTANCES OF THE DEATH** 1. The findings of fact on how Kevin died are set out above in the answers to the four statutory questions. **<u>Systemic failure and Kevin's death</u>** 2. The court made findings of fact upon the wider circumstances, namely the systemic failure that was possibly causative of Kevin's death. 3. On the day the ambulance call was made there were considerable ambulance delays. Whilst Kevin's priority remained category 2, during the period from the original 999 call to the onset of cardiac arrest (over four hours) there were no ambulances available for Kevin. 4. 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. Kevin waited over four hours and the reason the ambulance then attended was because Kevin's case was re-prioritised to Category 1 following the cardiac arrest. 5. Data provided to the court suggested that on the 16th January 2024 some Category 2 calls were having to wait 6 hours for an ambulance. 6. At approximately the time the ambulance call was made, 23:00 hours, there were 33 incidents awaiting allocation in Cornwall, including 20 that were Category 2. At this time South West Ambulance Service Trust (SWAST) reported that all ambulance resources were either responding to calls or delayed at hospitals (in the patient handover process). At the two main receiving hospitals for Cornwall, there were 12 ambulances delayed at Plymouth hospital and 22 ambulances delayed at Truro Royal Cornwall Hospital (RCHT). At this time SWAST was 123% resourced for anticipated demand in Cornwall, with a total of 45 ambulances available. This means approximately half of the allocated ambulances for Cornwall were delayed at RCHT. 7. The court found that the hospital has regularly failed to meet the 4-hour target for moving patients out of the Emergency Department (ED) during 2024. 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. 8. The court found insufficient bed availability on acute wards was attributable 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. 9. Approximately 80% of NCTR patients at RCHT 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

10. The court found significant correlation between delayed discharges, handover delays and delays in ambulance response times. On this basis, the court found there was a direct connection between the ambulance delay and inadequate social care provision, community hospital provision and primary healthcare support.
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 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. The court noted the SWAST systems report which found…

    ‘’….*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*.’’
21. 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.
22. 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…
23. 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.
24. 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.
25. 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) **Continuing average handover delays (and therefore response delays) which create a risk of future deaths**. The averages conceal spikes of delayed handover and ambulance response times which increase the risk of mortality. 2) **There is a direct connection between the risk of 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, shortage of beds in acute wards, and handover delays. This creates a risk of future systemic failures causing ambulance delays. 3) **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. 4) **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 [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 28 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: Kevin's family and SWAST. I have also sent it to other bereaved families who have experienced ambulance delays 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	**3 October 2024** **Guy Davies**