REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST TOUCHING THE DEATH OF

CHARLES GEORGE EDWARD DEVOS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **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. This report follows a number of previous regulation 28 reports issued by coroners in Cornwall on the subject of ambulance delays.
3	**INVESTIGATION and INQUEST** On 20 July 2023 an investigation was commenced into the death of 54-year-old Charles George Edward Devos. The investigation concluded at the end of the inquest on 2 December 2024. The medical cause of death was found as follows: *1a) Small bowel infarction* The four statutory questions - who, when, where and how – were answered as follows*:* *Charles George Edward Devos died on 9 January 2021 at Trevarthian Farmhouse Plain-an-Gwarry Marazion Cornwall from an acute bowel condition.* *Charles' death followed 999 calls by Charles' family at 22:55 hours and 23:47 hours on 8 January 2021 requesting an ambulance. There was a delay in South West Ambulance Service (SWAST) conducting a necessary clinical assessment to determine categorisation of priority. This delay denied Charles an opportunity to obtain potentially lifesaving*

	treatment at hospital. Charles died at home on 9 January 2021 shortly after the arrival of paramedics. *This missed opportunity is attributable to the extreme operational pressures exerted upon SWAST which was a direct result of the failure of the whole system of health and social care which adversely influenced or delayed decisions made by SWAST.* The conclusion of the inquest was as follows: *Charles died from a treatable bowel condition following a missed opportunity to obtain potentially lifesaving treatment. This opportunity was missed due to extreme operational pressure on ambulance services following the failure of the system of health and social care which was possibly causative of Charles' death.*
4	**CIRCUMSTANCES OF THE DEATH** 1. Charles' family called 999 on 8th January 2021 at 22:55 hours requesting an emergency ambulance. Charles was reported to have vomited and was sweating in a hot and cold fever, and in dreadful abdominal pain. The call was referred for clinical assessment in order to determine categorisation of priority. 2. There was a further 999 call at 23:47 from Charles' family due to the severity of his symptoms. 3. There was a conversation between call handler and a clinical adviser about whether to upgrade the call for an emergency ambulance. The clinical advisor was informed that Charles was reported to have vomited and to be rolling around in pain and that Charles could be heard by the call handler to be screaming in agony. 4. The clinician decided the appropriate course of action was for clinical triage. Due to severe operational pressure the clinician did not have time to conduct clinical assessment herself at that time. The 999 call was again referred for clinical assessment in order to determine categorisation of priority. 5. Clinical assessment was further delayed until a call back by a clinician at 03:15 hours on 9 January 2021. 6. The court found that the reported symptoms at 23:47 likely necessitated the prioritization of Charles' clinical triage which should have taken place at 23:47 or shortly thereafter. 7. If triage had taken place at 23:47 or shortly thereafter it is possible that triage would have led to an emergency ambulance being arranged. This is because triage would have been taking place at a time when Charles was still suffering the initial symptoms of acute bowel ischemia. 8. If an emergency ambulance had collected Charles in the early hours of 9 January, it is probable that he would have received lifesaving treatment. The sooner that he could have been taken to hospital for surgery the likelier it is that he would have survived. 9. The court found that the delay in clinical assessment amounted to a missed opportunity to provide potentially curative surgery. 10. By the time of the clinician call back at 0315, Charles' condition had worsened but the presentation had altered so that it appeared to have improved. On the false belief of improvement Charles agreed to self-convey to hospital but did not do so. 11. By the time Charles' family called again for an ambulance on the afternoon of 9 January it was too late. His condition had deteriorated to such an extent that it was not survivable. 12. Charles died at home shortly after the arrival of paramedics. SYSTEMIC FAILURE IN 2021 13. The court heard that on 8th January 2021 the ambulance service lost 109 hours of ambulance availability to handover delays at Royal Cornwall Hospital (RCHT). This excludes the 15-minute allowance for each handover. That is the equivalent to losing ten, 12-hour

ambulance shifts. This led to significant delays in ambulance response times due to the numbers of ambulances detained at hospital.

14. As a consequence of handover delays there was a significant volume of unallocated emergency calls to the ambulance service, awaiting ambulances, triage or assessments.
15. The court found that severe and extreme operational pressure on SWAST influenced or delayed necessary decisions.
16. Reports from SWAST and the Health Services Safety Investigation Body (HSSIB) found a strong correlation between handover delays and ambulance response delays.
17. The SWAST report stated:

    The investigation 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.
18. The reports indicated a direct connection between ambulance delays and inadequate social and community care. 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 emergency departments (ED) and the inability of ambulances to handover patients to ED.
19. There was no culpability on the part of SWAST call handlers or clinicians who were doing their best to mitigate the risks created by the systemic failure.
20. 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 and community care provision. They are unable to influence the whole-system and therefore carry risks that they cannot wholly mitigate or manage.
21. 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.
22. The court found that the extreme and severe pressure on SWAST can be attributed to by a systemic failure of the entire system of health and social care.

SYSTEMIC FAILURES IN 2024

23. Significant average handover delays at RCHT were recorded for every month of 2024 up the date of Inquest.
24. SWAST witnesses stated that the average handover delays conceal spikes which exert severe operational pressure. Such long delays increase the risk of mortality.
25. The court heard evidence of extreme mitigating measures being deployed by SWAST and other ambulance services across England and Wales seeking to reduce risks following ambulance delays. The court discussed the hypothetical example of a patient with a suspected heart attack facing a long ambulance delay. The court heard that due to the risks associated with ambulance delays a number of mitigating measures would be pursued in circumstances where ordinarily an emergency ambulance would be provided. These included:

    - **Self-conveyance**: recommending that the patient arrange for family or friends to convey them to hospital with safety netting advice if the condition worsens (namely pull over and call 999).
    - **Taxis**: Arranging taxis to collect said patients if family or friends cannot assist.
    - **Unattended drop offs**: Ambulance paramedics wheeling patients into emergency departments on spare ambulance beds notwithstanding there being no available bed for that patient in ED, and leaving the patient unattended by ambulance crews, in order to release ambulances to attend to other calls.

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) Extreme operational pressure on ambulance services leading to volumes of unallocated 999 calls and excessive ambulance delays. There is a direct connection between the extreme operational pressure on SWAST and inadequate social and community care provision. This is because the inadequacy in these services creates a risk of future systemic failures causing excessive volumes of unallocated 999 calls and ambulance delays. (2) Ambulance call handlers and clinical advisors are being forced to resort to extreme mitigating measures to try and manage risks created by the systemic failures. These measures are being relied on in circumstances where ordinarily an emergency ambulance would be provided. The mitigating measures include resorting to recommending self-conveyance, arranging taxis and unattended drop offs at ED.
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 4 February 2025. 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 Charles' family and SWAST. 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	**10 December 2024** **Guy Davies**