REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF ANDREW WATERS

	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.
3	**INVESTIGATION and INQUEST** On 30 May 2024 I commenced an investigation into the death of Andrew Waters. The investigation concluded at the end of the inquest on 13 March 2025. The medical cause of death was found to be as follows *1a Cardiogenic Shock* *1b Myocardial Infarction* *1c Coronary Artery Disease* The four questions – who, when, where and how were answered as follows *Andrew Waters died on 24 May 2024 at Royal Cornwall Hospital Truro (RCHT) from complications of an undiagnosed and untreated heart condition following an ambulance delay attributable to a systemic failure related to the whole system of health and social care.* *Andrew's family made a 999-call requesting an ambulance at 02:37 hours on 24 May 2024, at which time Andrew was exhibiting clear symptoms of a heart attack. The ambulance service allocated a category 2 priority but there were no ambulances available to respond.* *The ambulance service despatched a taxi at 04:40 hours which collected Andrew who arrived at Royal Cornwall Hospital at 05:37 hours. There was a delay of 3*

	hours from the original category 2 priority decision to Andy's arrival at RCHT. *Andrew went into cardiac arrest almost immediately after arrival at RCHT Emergency Department. Subsequently despite emergency heart surgery the medical team were unable to save Andrew's life. Andrew's heart condition was treatable prior to his cardiac arrest. The impact of the cardiac arrest meant his condition became unsurvivable. The ambulance delay denied Andrew the opportunity of potentially lifesaving treatment.* The conclusion of the Inquest was as follows. *Andrew died from an undiagnosed and 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 Andrew potentially lifesaving treatment.*
4	**CIRCUMSTANCES OF THE DEATH** 1. The findings of fact on how Andrew died are set out above in the answers to the four statutory questions. 2. The court made findings of fact upon the wider circumstances, namely the systemic failure that was possibly causative of Andrew's death. **Significant handover delays** 3. At the time of Andrew's 999 call there were 7 ambulances delayed at RCHT due to an inability to handover their patients to the hospital emergency department (ED). 4. In Andrew's case the unavailability of ambulance resources meant that the South West Ambulance Service Trust (SWAST) had to resort to sending a taxi to try and get Andrew to hospital in time. The taxi driver was not informed that the ride was for a patient having a heart attack. Nevertheless, the taxi driver made every effort to get Andrew to hospital as quickly as lawfully possible. 5. The court noted that the national target is for ambulances to handover patients to hospital is within 15 minutes of arrival. 6. At RCHT on 23rd May 2024 the average handover time per patient was one hour, 25 minutes, 46 seconds, with over 101 hours of ambulance time lost to handovers above 15 minutes in duration. This is equivalent to approximately nine ambulance shifts lost to delays (based on a standard 11-hour shift). 7. At RCHT on 24th May 2024 the average handover time was 50 minutes, 20 seconds per patient with over 49 hours of ambulance time lost to handovers above 15 minutes in duration. This is equivalent to approximately four ambulance shifts lost to delays. 8. Data indicates the picture has not improved. Significant average handover delays at RCHT were recorded for every month of 2025 to date. This is a picture reflected across the south west and indeed nationally. 9. 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. 10. The court heard evidence of a new policy being implemented by SWAST to try and reduce ambulance resources being tied down in lengthy waits at hospital. After a 90-minute handover delay the ambulance paramedics will give notice to ED that a patient is being left on a trolley, notwithstanding the fact that ED has not formally accepted that patient, and despite evidence of concerns around ED crowding.

ED crowding

11. On the day of Andrew's ambulance delay, RCHT ED was at 130% occupancy. ED accommodated these patients on trolleys in corridors, and the rest of the patients would either be seated within the waiting room or remain inside ambulances outside.
12. Similar data was presented to the court for January 2025.
13. EDs have a national target for 95% of patients to be admitted, transferred or discharged within 4 hours. 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. This increased mortality is partly attributed to the fact that patients in ED are not receiving the surgery or specialist care that is available on the wards.
14. The court found that on 24 May 2024 the hospital failed to meet the 4-hour target for the majority of patients.
15. Recent data indicated there has been no significant improvement on meeting the 4- hour target, with RCHT ED failing to meet that target for the majority of patients.

Insufficient social care provision

16. The court found there was insufficient bed availability on acute wards which was attributable to significant numbers of patients in hospital with no reason to reside (NCTR), these being patients who are medically optimised but cannot be discharged due to lack of onward care support.
17. On the day of the ambulance delay, 24 May 2024, almost 20% of patients in RCHT were recorded as NCTR.
18. In January 2025 the proportion of NCTR patients was over 20% of patients in RCHT.
19. The court noted the main cause for the numbers of NCTR patients was insufficient social care provision, whether commissioned by social services or NHS.
20. Investigations in 2022 and 2023 by SWAST and the Healthcare Safety Investigation Branch (HSIB) found a direct link between ambulance delays and inadequate social care provision. 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. Data presented to the court indicated that just over 10% of direct 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 just under 10% nationwide vacant direct social care posts.
22. The court noted that 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.
23. The HSIB report referred to the fact that 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.
24. 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) Significant handover delays leading to ambulance resources being tied up at hospital with increased risk in mortality for patients in the community waiting for emergency ambulances. (2) ED crowding leading to increased risk in mortality for patients being held in ambulances and corridors and being delayed from receiving surgery or specialist treatment on wards. (3) Insufficient social care provision leading to large numbers of patients in hospital who are otherwise fit for discharge, thereby impeding patient flow through hospital.
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 31 May 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 the following Interested Persons: Andrew's family, RCHT and SWAST. I have also sent it to the following organisations who may find it useful or of interest: Cornwall Council Adult Social Care, NHS Cornwall Integrated Care Board. 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	**3rd April 2025** **HMC Guy Davies**