REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF JAMES FREDERICK SMITH

	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 4 July 2024 I commenced an investigation into the death of 82-year-old James Frederick SMITH, known as Jim to family and friends. The investigation concluded at the end of the inquest on 14 April 2025. The medical cause of death was found to be as follows: *1a Pulmonary Embolus* *1b Deep Vein Thrombosis* *1c Fall and Fractured Neck of Femur* *II Dementia* The four questions - who, when, where and how – were answered as follows: *James Frederick SMITH died on 25 June 2024 at Royal Cornwall Hospital Truro Cornwall from complications whilst in the operating theatre following trauma consistent with a fall on 22 June 2024, contributed to by a total ambulance delay of 17 hours and 52 minutes.* *The ambulance delay comprised a response delay of 12 hours and 8 minutes. During that time Jim suffered a long lie on the floor with a fractured hip, overnight 22nd into 23rd June 2024. Jim then suffered a handover delay of 5 hours and 42*

	minutes, waiting in the ambulance for that time before being admitted to the hospital emergency department. *The ambulance delay is likely to have contributed to Jim developing a deep vein thrombosis, a complication which led to his death on the operating table. The medical team had decided to operate due to Jim's severely critical condition and were aware of the deep vein thrombosis but there was no realistic alternative to an operation.* *The ambulance delay was attributable to a systemic failure related to the whole system of health and social care.* The conclusion of the inquest was as follows: *Jim died whilst undergoing necessary surgery following trauma consistent with a witnessed fall and long lie. Jim's death was contributed to by an ambulance delay which was attributable to a systemic failure related to the whole system of health and social care. The ambulance delay was possibly causative of Jim's death in that it likely contributed to the pre-operative complications which led to Jim's death on the operating table.*
4	**CIRCUMSTANCES OF THE DEATH** 1. The findings of fact on how Jim 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 Jim's death. **Significant handover delays** 3. At the time of Jim's 999 call, 22 June 2024, the South West Ambulance Service (SWAST) reported multiple ambulance crews were stacking at Royal Cornwall Hospital Truro (RCHT). There were no ambulances or Community First Responders (CFRs) available to respond. 4. In Jim's case the unavailability of ambulance resources meant that he spent 12 hours on the floor waiting for an ambulance, unable to move due to a fractured hip. 5. On arrival at RCHT, Jim spent a further 5 hours and 42 minutes waiting to be admitted to the emergency department. 6. The court noted that the national target is for ambulances to handover patients to hospital is within 15 minutes of arrival. 7. On 22 June 2024, there were over 473 hours of ambulance time lost to handovers that were over the 15 minute target at the three hospitals servicing Cornish patients, namely RCHT, Plymouth Derriford Hospital, and Barnstaple North Devon District Hospital (NDDH). This is equivalent to approximately 43 double crewed ambulance shifts lost to delays (based on a standard 11 hour shift). At RCHT on that day, the average handover time per patient was three hours. 8. On 23 June 2024, there were over 551 hours of ambulance time lost to handovers that were over the 15 minute target at RCHT, Derriford Hospital, and NDDH. This is equivalent to approximately double crewed ambulance shifts lost to delays (based on a standard 11 hour shift). At RCHT on that day, the average handover time per patient was, two hours, 42 minutes. 9. 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 southwest and indeed nationally. 10. 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. 11. 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 provide 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.

Emergency department crowding

12. On the day of Jim's ambulance delay, RCHT ED was at 140% 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.
13. The situation had not improved at the time of a data request from HM Coroner. The date of the request was 16 January 2025, on which date ED was recorded to be at 150% occupancy.
14. 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.
15. The court found that on 22 June 2024 the hospital failed to meet the 4-hour target for a significant number of patients.
16. Recent data indicated there has been no significant improvement on meeting the 4- hour target, with RCHT ED failing to meet that target for a significant number of patients.

Insufficient social care provision

17. 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.
18. On the day of the ambulance delay, 22 June 2024, almost 20% of patients in RCHT were recorded as NCTR.
19. In January 2025 the proportion of NCTR patients had increased to approximately 25% of patients in RCHT.
20. The court noted the main cause for the numbers of NCTR patients was insufficient social care provision, whether commissioned by social services or NHS.
21. 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.''
22. 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.
23. 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.
24. 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 and support. 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) Insufficient social care provision leading to large numbers of patients in hospital who are otherwise fit for discharge, thereby impeding patient flow through hospital, there being a direct link between inadequate social care provision and ambulance delays. (2) Significant handover delays at RCHT and other southwest hospitals leading to ambulance resources being tied up with increased response delays and increased mortality risks for patients in the community waiting for emergency ambulances. (3) 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.
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 8 July 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: Jim's family, RCHT, SWAST, Cornwall Council and Cornwall ICB. 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	**12 May 2025** **Guy Davies**