His Majesty's Senior Coroner for The County of Devon, Plymouth and Torbay
Philip Spinney

3 June 2025
Case ref: [redacted]
Date of Birth: **23 May 1947**

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Secretary for State for Health and Social Care

CORONER

1 I am Stephen Covell an Assistant Coroner for The County of Devon, Plymouth and Torbay

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

The County of Devon, Plymouth and Torbay, County Hall, Topsham Road, Exeter, Devon, EX2 4QD
Telephone: [redacted] Email: [redacted]

INVESTIGATION and INQUEST

On 22 August 2022 I commenced an investigation into the death of Brian GARRICK.

The investigation concluded at the end of the inquest on 16 April 2025.

The conclusion of the inquest was;

Cause of Death : 1a Acute Myocardial Infarction.

II Ischaemic Heart Disease, Cerebrovascular Accident

3 How, When and Where : Brian Garrick died at 1145 on 10 August 2022 at Derriford Hospital Plymouth as a result of an acute cardiac event against a background of long standing ischaemic heart disease.

Narrative Conclusion :

The Deceased started to experience acute cardiac symptoms of chest pain at 0130 on 10 August 2022. 999 was called at 0141 however an ambulance did not arrive until 0833 which was 5 hours later than normal service expectations. The Deceased was brought to hospital at 0945 and the cardiac procedure commenced within 32 minutes. The delay in the Deceased being brought to hospital by ambulance after the onset of acute symptoms contributed to his death.

CIRCUMSTANCES OF THE DEATH

Brain Garrick was a 75 year old man who suffered from ischaemic heart disease involving hardening and narrowing of his cardiac arteries. The condition had been monitored over the years and he had been issued with a GTN spray to alleviate symptoms of angina.

At around 0130 in the early hours of 10 August 2022 Brian started to experience chest pains which were more severe than his previous experienced angina and were not alleviated by the GTN spray.

An ambulance was called at 0141 which was given a category 2 response which was appropriate for Brian's presentation. Service level guidelines for the ambulance service
4 required that 90% of responses to the patient should be within 40 minutes with a mean response time of 18 minutes. The ambulance arrived at 0833, nearly seven hours later, and conveyed Brian to hospital where he arrived at 0945. By 1012 Brian was undergoing a cardiovascular procedure to open a blockage which had been diagnosed in his left main stem artery. Sadly Brian suffered a cardiac arrest whilst the procedure was taking place and could not be resuscitated notwithstanding that the cardiac procedure was completed successfully. Brian was pronounced deceased at 1145 on 10 August 2022.

I calculated that if the service requirement for response times had been achieved Brian would have reached the hospital by 0330. I heard evidence from the treating cardiologist that the chance of successfully treating Brian's acute condition reduced with each passing hour between the onset of symptoms and treatment. I accepted his evidence that had Brian been conveyed to the hospital by 0330 it is likely that he would have survived.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern.

I heard evidence from the ambulance trust that on the night in question, despite the volume of calls to the service being at normal levels and crew and vehicle levels being also at normal levels, there were significant delays to ambulance response times due to long hand over times at the local acute hospitals which were preventing ambulances and their crews returning to service.

I heard evidence from the ambulance service that significant action has been taken at a local level by the ambulance and the hospital trusts to try to alleviate the problem and that some progress had been made, but that hand over times were still impacting on service delivery and that as such members of the public are at risk of not
5 receiving timely medical treatment for acute illnesses. I was informed that for further progress to be achieved strategic solutions at Governmental level were required to provide an effective solution.

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. Response times for ambulances attending acute medical incidents continue to be impacted by severe delays in patient handovers at acute hospitals preventing ambulances and their crews returning to service.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you Secretary of State for Health and Social Care have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th July 2025
7 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;

1. [redacted] from Brian's family

2. South West Ambulance Service Trust

8 3. Plymouth University Hospitals NHS Trust

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.

30 May 2025

9 Signature 

Stephen Covell Assistant Coroner for

The County of Devon, Plymouth and Torbay, County Hall, Topsham Road, Exeter, Devon, EX2 4QD
Telephone: [redacted] Email: [redacted]