HM CORONERS COURT

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF GEOFFREY GORDON FULLER

	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	**DATE OF REPORT** 18 June 2026
3	**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.
4	**THIS REPORT IS BEING SENT TO** 1. The deceased Mr Fuller's family 2. The Chief Coroner for England and Wales 3. Royal Cornwall Hospital Trust (RCHT) 4. South West Ambulance Service Trust (SWAST) You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 August 2026. I, the coroner, may extend the period if an appropriate application is made.
5	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner.

	In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	**SUMMARY OF CORONER'S CONCERN** (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.
7	**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.
8	**INVESTIGATION and INQUEST** On 14 July 2026 I commenced an investigation into the death of 91-year-old Geoffrey Gordon Fuller. The investigation concluded at the end of the inquest on 8 June 2026. The medical cause of death was established on the evidence as follows: *1a Ruptured Abdominal Aortic Aneurysm* *II Ischaemic Heart Disease* The four questions - who, when, where and how – were answered as follows: *Geoffrey Gordon FULLER died on 8 July 2025 at Royal Cornwall Hospital Treliske Truro from a ruptured Abdominal Aortic Aneurysm* My conclusion as to the death was as follows: *Natural causes*
9	**CIRCUMSTANCES OF THE DEATH** Mr Fuller called for an ambulance due to a dislocated hip. There followed a 13-hour ambulance delay during which time 91-year-old Mr Fuller had to endure unnecessary pain and suffering. During his subsequent admission Mr Fuller died of a condition unrelated to the dislocated hip, namely a ruptured aneurysm. The ambulance delay did not more than minimally contribute to the ruptured aneurysm.

10 **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. –

Significant handover delays

1. The court noted that the NHS national target is for ambulances to handover patients to hospital is within 15 minutes of arrival.
2. The total ambulance delay on 7 July 2025 for Mr Fuller was approximately 13 hours, involving delays in both response and handover.
3. The delay in ambulance response was 10 hours and 12 minutes, during which time Mr Fuller was in pain and unable to move due to a dislocated hip.
4. On arrival at Royal Cornwall Hospital (RCHT), Mr Fuller spent a further 2 hours and 52 minutes before being handed over to the emergency department.
5. On 7 July 2025, at RCHT, the average handover time was two hours, 24 minutes with over 211 hours of ambulance availability lost to these handover delays. This is the equivalent of approximately 19 double crewed ambulance (DCA) shifts lost to delays (based on a standard 11-hour shift).
6. Data for the two months before Mr Fuller's death reveals average handover delays at RCHT of 1 hour and 26 minutes for May 2025, and 1 hour and 27 minutes for June 2025 (beyond the 15 minute target).
7. Recent data indicates the picture has not improved. Significant average handover delays at RCHT were recorded for every month of 2026 to date (beyond the target 15 minutes). The data for May 2026 indicates an average handover delay of 1 hour and 22 minutes beyond the 15-minute target.
8. The day before this Inquest, 7 June 2026, SWAST recorded average handover delays at RCHT of 1 hour and 10 minutes.
9. These handover delays lead to the unavailability of ambulances to respond to emergency calls. Furthermore, 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 provide notice to ED that a patient is being left on a trolley in a corridor with fluids and medications if required so long as that patient is stable. This has led to significant crowding in RCHT emergency department (ED).

Emergency department crowding

1. On the day of Mr Fuller's ambulance delay, RCHT ED was accommodating 105 patients. ED has a capacity of 42 patients. ED accommodated the surplus patients on trolleys in corridors, seated within the waiting room or remaining inside ambulances in the parking area outside ED.
2. The situation had not improved as at the date of this Inquest.
3. 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.
4. Data indicates that RCHT have been failing to meet the 4-hour target for a significant number of patients. For the opening months of 2026 approximately 50% of patients have still been in ED after 4 hours.
5. RCHT witnesses reported that over the last few weeks the ED has been regularly

	required to accommodate over 100 patients (in a unit with a capacity for 42 patients). This has involved significant numbers of patients still in ED after 12 hours, some still in ED after 24 hours. **Insufficient social care provision** 1. 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. 2. On the day of the ambulance delay, 7 July 2025, almost 20% of patients in RCHT were recorded as NCTR. 3. The court noted the main cause for the numbers of NCTR patients was insufficient social care provision, whether commissioned by social services or NHS. 4. 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."* 5. This court has previously noted data indicating significant vacancies in social care posts in Cornwall are vacant reflecting the national picture of nationwide vacant direct social care posts. [*see previous PFD reports on this subject*] 6. 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. 7. The HSSIB 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. 8. 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.
11	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to Mr Fuller's family. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

	SIGNATURE [redacted] **HMC Guy Davies**