HM CORONERS COURT

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF ANTHONY FRANCIS EDWARDS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
2	**DATE OF REPORT** 9 September 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** [redacted] Secretary of State for Health and Social Care You are under a duty to respond to this report within 56 days of the date of this report, namely by 4 November 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** There is a shortage of nurses in the NHS creating a risk of future deaths.
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 83-year-old Tony. The investigation concluded at the end of the inquest on 6 August 2026. The medical cause of death was established on the evidence as follows: *1a Aspiration Pneumonia* *1b Operated On Neck Of Femur Fracture* *1c Fall* *2 Oropharyngeal Dysphagia, Peripheral Vascular Disease, Type 2 Diabetes, Atrial Fibrillation, Hypertension, Parkinson's Disease, Chronic Obstructive Pulmonary Disease* The four questions - who, when, where and how – were answered as follows: *Anthony Francis EDWARDS (known as Tony) died on 1 September 2025 at Royal Cornwall Hospital Treliske Truro from complications following trauma, namely a fractured neck of femur, after falling from his mobility scooter on 23 August 2025.* *Tony was admitted to Royal Cornwall Hospital on 23 August 2024 and was listed for a routine half hip replacement which is recommended to be undertaken the day of admission, or the day after, to avoid complications which can follow any delay. Tony was clinically fit for this operation from the 24 August 2025 and was considered to be at high risk of mortality due to Parkinsons disease and other physical health conditions.* *The operation was delayed until 28th August 2025 due to staff shortages and other operational pressures. During each day of this period Tony was nil by mouth in anticipation of having an operation which was cancelled at the end of each day. Tony's condition deteriorated during this period, and it was found that the delayed operation and the associated periods of nil by mouth contributed more than minimally to Tony's death.* My conclusion as to the death was as follows: *Accident contributed to by neglect.*

9	**CIRCUMSTANCES OF THE DEATH** The circumstances are adequately reflected in the answers to the four questions - who, when, where and how – set out above.
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. – The court found that at at Royal Cornwall Hospital Treliske Truro (RCHT) on four consecutive days, 24th to 27th August 2025, a routine operation for a half hip replacement for Tony was cancelled. The reason for these cancelled operations was found to be a lack of nursing staff within the surgical team and not a lack of surgeons or anaesthetists. The operation went ahead on 28th August 2025. During each day of this period Tony was nil by mouth in anticipation of this operation. Tony's condition significantly deteriorated during this period and was under treatment for pneumonic symptoms from 26 August 2025. Tony was recognised to be at high risk of mortality due to his co-morbidities. Guidelines require such an operation to be conducted on the day of admission or the day after at the latest. The court found that the cancelled operations and the associated periods of nil by mouth directly contributed to Tony's death. The court found that at the time of Tony's death at RCHT there was a 12% vacancy rate for nurses and healthcare assistants. The vacancy rate for these staff at RCHT at the date of Inquest was found to be 11%. This reflected a national figure of 21,000 vacancies for nurses and healthcare assistants. The court found there were difficulties regarding recruitment and retention of nursing staff. Evidence indicated that the increased workload (due to staff shortages) contributed to low morale. This adversely impacted the retention rate for nurses and contributed to a rising sickness absence rate amongst nurses at Treliske. Recruitment was also reported to be problematic notwithstanding well publicised campaigns by Treliske. A lack of trained nurses was partially attributed to the cost of student fees imposed on student nurses following the cessation of bursaries. In addition, the inability of student nurses to take on part-time work to fund their studies due to full-time placements on hospital wards.
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: 1. Tony's family 2. RCHT 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  **HMC Guy Davies**