# Coroner raises concerns over NHS failures following man's death



A coroner has raised serious concerns regarding the ongoing issues within the National Health Service (NHS) after a man died following what has been described as "systematic" failures. The coroner's remarks came during an inquest into the death of Andrew Waters, a 56-year-old resident of Indian Queens, Cornwall, who passed away at Royal Cornwall Hospital.

The inquest, conducted on March 13, revealed that Mr Waters, who was generally healthy apart from an undiagnosed heart condition, experienced severe pain on the evening of May 23, 2024. Initially treating his symptoms as indigestion, which included worsening chest pain, he eventually sought emergency assistance when the pain escalated.

His wife contacted emergency services in the early hours, reporting chest pain, arm numbness, nausea, and tremors. This call was assessed and classified as a Category 2 call—indicating the second highest urgency by the South Western Ambulance Service NHS Foundation Trust (SWASFT). Despite this, an ambulance did not arrive, and a call handler was compelled to request a taxi for Mr Waters at around 4.40am. It wasn’t until 5.37am, nearly three hours after the initial 999 call, that he reached the hospital, where he suffered a heart attack upon arrival.

Despite the swift response of medical personnel who undertook various urgent procedures, including emergency heart surgery, they were ultimately unable to save Mr Waters. Commenting on the circumstances surrounding her husband's death, Mrs Waters expressed her dissatisfaction with the response time, stating, “I am angry, I am sad and I don't believe this should have happened. To have been sent a taxi is disgusting.” However, she did commend the medical staff at the hospital for their efforts once he arrived.

Coroner Guy Davies identified multiple systemic failings during the inquest, citing significant delays in patient handover, overcrowding in emergency departments, and inadequate provision of social care. In light of his findings, he intends to issue a Prevention of Future Deaths report, which alerts authorities to concerns regarding potential future incidents.

Davies expressed that there is an evident risk of similar tragedies occurring unless remedial action is taken. In his communication with the Secretary of State for Health and Social Care, he stated, “In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action.” The Secretary of State has been requested to respond by May 31, 2025.

This incident underscores the ongoing challenges facing the NHS, particularly concerning emergency responses and access to timely care.

Source: [Noah Wire Services](https://www.noahwire.com)

## References

* <https://www.judiciary.uk/prevention-of-future-death-reports/andrew-waters-prevention-of-future-deaths-report/> - This report elaborates on the inquest findings related to Andrew Waters' death, highlighting concerns about systemic failures in the NHS. It supports the coroner's remarks and the intention to issue a Prevention of Future Deaths report.
* <https://www.thefreelibrary.com/Woman+'disgusted'+as+taxi+sent+instead+of+ambulance+for+husband's...-a0831697685> - This article provides details about the emergency response situation where a taxi was sent instead of an ambulance for Andrew Waters, corroborating the dissatisfaction expressed by his wife.
* <https://www.judiciary.uk/prevention-of-future-death-reports/kenneth-heard-prevention-of-future-deaths-report/> - This report highlights similar systemic issues, such as ambulance delays and patient handover problems, that have led to concerns about future incidents in Cornwall, reinforcing the coroner's concerns about the NHS.
* <https://www.noahwire.com> - The original source article provides a comprehensive overview of Andrew Waters' case and the concerns raised by the coroner about NHS systemic failures.
* <https://www.gov.uk/government/organisations/department-of-health-and-social-care> - This government website details the Department of Health and Social Care's responsibilities, which align with the coroner's report addressed to them regarding NHS service improvements.