HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

[redacted]

HM Coroner Mrs Joanne Lees
Coroner's Court
Jack Judge House
Halesowen Street
Oldbury
B69 2AJ
[redacted]

8 January 2023

Care Quality Commission
[redacted]

Dear HM Coroner

Prevention of future death report following inquest into the death of Miss Lauren Page Smith

Thank you for sending CQC a copy of the prevention of future death report issued following the death of Miss Lauren Page Smith. The report identifies concerns about the care provided by West Midlands Ambulance Service NHS Foundation Trust on 6 January 2023.

We note the legal requirement upon us to respond to your report within 56 days.

Your prevention of future death report asks CQC to respond to the following information raised in point 14 of the report:

'I am concerned that there has been no collective learning by West Midlands Ambulance Service following the death of Lauren Smith. There has been no action to address the learning gaps identified by WMAS own internal investigation report in respect of both the paramedic and technician. Therefore, I have addressed this aspect of my PFD to the CQC/Chief Inspector of Hospitals/HSIB as part of their regulation as to the safety of the West Midlands Ambulance Service considering the risk I have identified in relation to patient safety due to inaction by WMAS'.

We carried out core service inspections of WMAS covering urgent and emergency care and the emergency operations centre on 15 to 17 August 2023. An inspection of the well led key question was also carried out between 3 and 5 October 2023. The draft report for these inspections is currently with the provider

for a factual accuracy check. We will share the report with you when it is finalised.

During our inspection, we identified the need for improvements to be made to the processes around serious incident management and learning from deaths. Specifically, there was a focus at the trust around the quantity and timeliness of serious incident investigations rather than on the learning required as a result of the outcome of the investigations.

As you may be aware, CQC has been the lead enforcement body for health and safety incidents in the health and social care sector since 1 April 2015. As such, we contacted WMAS and requested evidence of the action they had taken to date following Miss Lauren Page Smith's death and any additional action they intended to take in response to the prevention of future death report.

Having carefully reviewed the information the trust has provided, we have concluded there is no evidence of provider level failing in relation to Miss Lauren Page Smith's death. However, we did identify concerns that supported our inspection findings in relation to the serious incident investigation process, and in particular, the timeliness around addressing the training needs of the staff involved with Miss Lauren Page Smith's care.

The updated WMAS action plan dated 2 November 2023 and our ongoing communications with WMAS has demonstrated that the training needs of one staff member have now been addressed and the second staff member's training needs will be met on their return to work.

We will continue to monitor WMAS's progress in making improvements to their serious incident management and learning from deaths through our ongoing monitoring activities and engagement.

Yours sincerely

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Deputy Director of Operations, Midlands Network