

HM Senior Coroner Alan Wilson

HM Senior Coroner Blackpool & Fylde

22 April 2026

Care Quality Commission

Dear HM Senior Coroner Wilson,

Prevention of future death report following inquest into the death of Janet Springall

Thank you for your Regulation 28 Report dated 7 February 2026 concerning the sad death of Janet Springall. We wish to express our condolences to Janet Springall's family.

Although the Care Quality Commission (CQC) was not an Interested Person at the inquest, your report records an assertion made verbally that:

- clinical staff had previously been able to attend patients in ambulances outside the hospital; and
- this no longer occurred because of *guidance from the Care Quality Commission*.

Given that this assertion related directly to assumed CQC guidance, we considered it necessary to undertake a focused internal review to determine whether CQC had issued any instruction or advice that could have contributed to a change in practice.

CQC have carefully considered whether CQC issued guidance relating to the treatment of patients on ambulances. Following receipt of the Regulation 28 report, CQC reviewed:

- Inspection documentation for the 3 inspections carried out at the trust between 2021 and 2022;
- Audio from relevant parts of the inquest where this assertion was mentioned;
- And our publications and guidance from 2021 onward

CQC have also sought further information from the trust on the nature of the alleged guidance indicated during the inquest.

[Redacted]

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[Redacted]

[Redacted]

The trust informed CQC that the comment was made verbally by a member of the trust staff, who said she believed it had been advice provided during one of the inspections conducted between 2021 and 2022. She recalled the advice being given in the context of an incident where a patient had come to harm and where nurse to patient ratios in the department were affected by a member of staff leaving the department to attend an ambulance.

CQC have done a focussed review on the inspection reports, enforcement documentation and some inspection notes that would ordinarily capture such concerns or advice.

There is no written record of any incident matching the description provided, nor any written evidence of CQC instructing or advising the trust that clinical staff should not treat patients on ambulances.

Only one of the inspection leads involved remains employed by CQC, and although she has reviewed her notes, she does not recall giving such advice.

CQC Position

CQC has not issued any written guidance, instruction, or policy stating that clinical staff should not treat patients who remain on ambulances. Our published information and judgements in annual reports such as the State of Care acknowledge that ambulances are not the ideal environment for sustained care, but this is intended to highlight the risks associated with delays, not to prevent clinicians from treating patients when that is the safest immediate option. The 2021 State of Care report stated: *“Ambulance handover delays are a consistent risk to the quality and safety of patients’ care. Although the care from ambulance crews during these waits tends to be good, ambulances are not the right locations to care for people once they have arrived at the emergency department.”*

For clarity, CQC inspectors do not provide operational clinical advice to providers, including advice about how or where treatment should be delivered to specific patients. This is not within CQC remit, and inspection teams are trained to ensure that their role is to assess and report on the quality and safety of care, rather than to direct clinical practice. CQC recognises that informal conversations during inspections can sometimes lead to differing interpretations and CQC are committed to being as clear as possible about the limits of our role. However, CQC are unable to evidence that a conversation covering these issues took place during our inspection.

From CQC’s review of the inspection findings across the 3 visits between 2021 and 2022, it is clear that CQC consistently raised concerns with the trust about ambulance handover delays and the number of people awaiting care in ambulances. In November 2025 CQC inspected the urgent and emergency care services at the trust. We did not find or escalate any concerns related to the quality and safety of ambulance handover processes during this inspection.

Actions Taken and Ongoing Work

Although CQC cannot evidence whether the guidance referenced during the inquest was or was not issued on-site by the inspection team, CQC recognise the seriousness of the risk identified in your report.

CQC will:

1. **Re-emphasise in our engagement with the trust** the importance of safe clinical escalation processes for patients awaiting offload in ambulances, including clear policies on when clinical staff should attend patients outside the department.
2. **Continue to monitor ambulance handover delays** and their impact on patient safety at the trust through our ongoing regulatory activity, gathering evidence from the people who use services, frontline staff, NHS Ambulance services and system partners.
3. **Provide refresher training for inspectors** ensuring they are aware of our role and remit, and aware of the limitations on our remit which prevent our teams providing individualised guidance to providers. This guidance will also be made clear to providers during our inspections to ensure all parties understand CQC's role and remit to assess and report on the quality and safety of care, rather than to direct clinical practice.

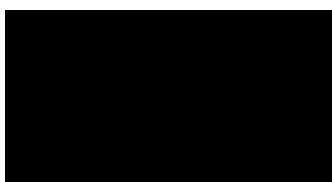
CQC will continue to use its regulatory powers to ensure that the trust maintains effective systems to identify deteriorating patients, including those waiting outside the department, and manages risks within the emergency care pathway.

Conclusion

Our internal review has found no evidence; written or verbal within our records that CQC advised the trust not to treat patients on ambulances. CQC remain committed to encouraging care services to improve by working with the trust and system partners to ensure that patients receive safe and timely care, including during periods of sustained operational pressure.

Please let us know if you require any further information.

Yours sincerely,



Deputy Director
Network North- HSSC
Care Quality Commission