	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Minister of State for Health [Secondary Care]** **Department of Health & Social Care** **C/O** Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU [redacted] **Care Quality Commission** By email – [redacted]
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
2	**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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The death of Janet Springall on 27th January 2025 was reported to me and I opened an investigation, which concluded by way of an inquest on 22nd January 2026. I determined that the medical cause of death was: 1a Sepsis 1b Pneumonia II Rheumatoid arthritis on immunosuppressant medication In box 3 of the Record of Inquest I recorded as follows:

	Janet Springall was aged 68 years. She had a learning disability and her medical history included previously diagnosed rheumatoid arthritis for which she was treated with immunosuppressant medication, placing her at increased risk of developing infection. After a period of six weeks in hospital, she was discharged to a care home on 10th January 2025 where she was visited regularly by her Sister. She could be reluctant to accept food and fluids. From approximately late afternoon on Thursday 23rd January 2025 she ate very little and ingested minimal fluids. On Sunday 26th January 2025 at shortly before 1.30 pm her Sister arrived to visit Janet and found her unresponsive but breathing. It is reported that a carer had seen Janet around fifteen minutes earlier, when Janet had rejected her medication but otherwise raised no concerns. From the available evidence, it cannot be stablished exactly when her condition began to deteriorate, but the deterioration had not been fully appreciated, thereby reducing the chances of Janet making a full recovery. An ambulance was requested and upon arrival, a paramedic found Janet unresponsive and hypoglycaemic. With medical assistance including intravenous glucose, she revived and was transferred to the local accident & emergency department where she was triaged at 16.58 hours that afternoon. Due to the very high number of patients in the department that day, many including Janet had to remain on ambulances. Over subsequent hours, her condition remained concerning and on occasions a paramedic sought to escalate her care with hospital staff but capacity pressures did not ease and it was not until 10.45 pm when she entered hospital. She was then reviewed by a doctor, a blood test performed and it was ascertained Janet was in septic shock and by 00.26 hours her condition was regarded as likely to prove non - survivable. Janet died at 00.42 hours on 27th January 2026. A post mortem examination confirmed Janet had pneumonia which had caused an overwhelming sepsis response and multi - organ failure which proved fatal. From the available evidence, by the time she arrived at hospital, Janet was very unwell and likely to die even if she had received a timely clinical assessment and necessary treatment including antibiotics. In the absence of such treatment, from approximately 7.30 pm that evening, any subsequent treatment would not have altered the outcome. In box 4 of the Record of Inquest I determined the conclusion to be one of: **Natural causes**
4	**<u>CIRCUMSTANCES OF THE DEATH</u>** In addition to the contents of section 3 above, the following is of note: • Janet Springall had a learning disability, was immunosuppressed and at increased risk of infection, and due to pressures on the emergency department had to remain for many hours in the ambulance outside of the hospital. Paramedics, aware she was at serious risk of a life-threatening infection and required urgent treatment, raised their concerns but it was not possible to offload Janet from the ambulance for almost six hours after arrival. • During the inquest, I was told as follows:

	• In the past, in the event a patient had to remain on the ambulance outside hospital, it was possible for clinical / nursing staff to leave the hospital to provide some treatment on the ambulance; • This no longer happens, and the court was informed this follows guidance from the Care Quality Commission [the CQC were not an Interested Person for this inquest] • An experienced Clinical Matron provided helpful evidence to the court, and she explained how in terms of available resources, should nursing staff exit the hospital to conduct a blood test, for example, in an ambulance outside of the department this requires two members of staff to exit the emergency department which may leave often very unwell patients without urgent medical attention. • In Janet's case, an overwhelming sepsis response could not be confirmed until after midnight when blood test results were available. Had it been possible for hospital staff to access the ambulance to conduct a blood test earlier that day, once the results of that test were available, the administration of intravenous fluids and antibiotics may have mitigated the risk to her life. • Janet was clearly very unwell upon arrival at hospital, and I found that by the time she entered hospital, it became clear she would die. I also found that by around 7.30 pm that evening, any subsequent treatment would not have altered the outcome. • In the absence of urgent clinical assessment by hospital staff, the witnesses from the North West Ambulance Service, including the Paramedic who had been with Janet in the ambulance, explained how the focus of her care was on trying to ensure her condition remained stable and she did not deteriorate whilst before she could enter the department. • Triage consisted of a discussion between the paramedic and the triage nurse inside of the department, and not in Janet's presence, at shortly before 5 pm that day. It would have been clear to the triaging nurse that such were the exceptional pressures on the day it was likely Janet would be able to enter the department for many hours. • An independent expert witness told the court how in his experience, there are circumstances in which the concerns for a patient are such that clinical staff will access the ambulance. This did not appear to be the position at hospital trusts in Blackpool. • There is no doubt that on the day Janet went to hospital, the emergency department was experiencing exceptionally high patient numbers, and significantly higher than other similarly departments in the other hospitals in the region on that day. • Blackpool Teaching Hospitals NHS Trust had conducted an internal review, and having considered that document, and having listened to evidence at the inquest, it appeared to me the Trust has made significant changes since Janet died with a view to minimising the number of patients who may have to wait on ambulances outside of hospital. This is to be welcomed. Having considered all of the above, I have determined that I have a duty to write this report.
5	**<u>CORONER'S CONCERNS</u>**

	During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to send the report: The **MATTER OF CONCERN** is as follows. – My concern is that notwithstanding the hospital Trust seems to have made welcome improvements, patients such as Janet Springall remain at risk. The Trust continues to experience significant pressures due to patient numbers, and unwell patients continue to remain in ambulances for some time before they are able to access the emergency department. When a very unwell patient has to remain on an ambulance due to very high demands placed upon a hospital emergency department, believed by paramedics to have a life-threatening infection, then in the absence of a blood test and the timely administration of any necessary intravenous fluids and antibiotics, the chances of such a patient surviving can be significantly reduced by the time the patient is able to access the emergency department. Janet Springall was very unwell by the time she arrived at hospital and was likely to die. Any realistic prospect she may recover had subsided by around 7.30pm, some 2.5 hours after arrival at hospital. Other patients may not be as unwell as Janet was upon arrival at hospital, and may therefore have more chance of surviving, but they too may deteriorate significantly whilst remaining in the ambulance before it can be confirmed they have an infection and receive timely medical attention and treatment. I believe it is necessary for to raise this concern, but it is not for me to be prescriptive about what should / can be done.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. Given the approaching holiday period I have extended this period to 5TH April March 2026. I, the coroner, may extend the period further. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • The family of Janet Springall

	• North West Ambulance Service • Blackpool Teaching Hospitals NHS Foundation Trust I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	07/02/26 Signature _ [redacted] Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**