Four years of published coroners' Section 28 reports on action to prevent future deaths in England and Wales

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Contents

	PAGE
Summary	Page 1
Introduction – coroners' warning reports and past failures of learning	Page 3
Database of 4 years of coroners' Section 28 warning reports, published up to 31 July 2017	Page 10
General results	Page 12
Numbers of Section 28 reports	Page 17
Austerity and decency	Page 19
Coroners' fire safety warnings before Grenfell	Page 21
NHS safety	Page 26
Proportion of coroners' warnings about the NHS	Page 23
Coroners' warnings about ambulance services and related matters	Page 32
Conclusion	Page 48
Appendix – Press criticism of CQC failure to act upon coroners' warnings and CQC response September 2015	Page 49

SUMMARY

In the recent years of austerity, the government has run an explicitly anti-red tape programme, purportedly business friendly but openly hostile to 'Health and Safety' regulations. [1] [2]

[1] In 2012 David Cameron PM reportedly stated that he would "kill off the health and safety culture for good"
http://www.independent.co.uk/news/uk/politics/david-cameron-i-will-kill-off-safety-culture-6285238.html

[2] Cabinet Office 'Cutting red tape programme'
https://cutting-red-tape.cabinetoffice.gov.uk/

This paper shares a database collated from four years of coroners' Section 28 warning reports about public safety that have been published by the chief coroner, and a broad initial report about the data.

Although it is positive that Section 28 reports have been published in recent years, I collated this data because the chief coroners' website is not searchable and does not give the public access sufficient, meaningful access to Section 28 reports. Patterns are further obscured by inconsistent indexing of cases. Some notable instances of miscategorisation of important cases were found (for example suicides, police related deaths, deaths in custody, deaths of armed forces personnel).

Questions also arise about the completeness of the data released. It is very likely that a number of reports have not been published.

Of the data that exists:

- At least 57.2 % (987 of 1725) of published Section 28 reports related to poor NHS care and hazards.

- Seventy Section 28 reports related to deaths in the custody of the State

- 350 Section 28 reports related to self inflicted deaths, whether through misadventure or by suicide.

- 60 Section 28 reports were about deaths where there had been neglect, including eight deaths in State custody.

- The majority of the 'neglect cases' were accounted for by the NHS.

There were no published responses at all to 62% (1070 of 1725) of Section 28 reports by organisations and persons who had been sent them for action to prevent future deaths. Moreover, no explanation is provided for this by the chief coroner's office.

The paucity of published responses is unexpected because past government records showed the vast majority of organisations previously responded to Rule 43 reports, which were the predecessor to Section 28 reports. Clarification is needed on whether response rates have deteriorated and or whether the Chief Coroner is choosing not to publish responses.

The lack of published responses to coroners' warnings raises questions about whether the audit cycle is being closed and therefore the effectiveness of public protection. The Grenfell fire being the most painful illustration possible of the consequences of such failure.

Relevant to fire safety, there were twenty published Section 28 reports in the last four years relating to fire safety, including recommendations for instalment of fire sprinklers and alarms in social housing, and the need to investigate the use of flammable insulating material in Hotpoint fridge freezers which can act as an accelerant.

In relation to NHS cases, notwithstanding the limitations of the coroners' data, a number of recurring themes are evident, raising questions about organisational learning. Coroners highlighted a lack of resources in a number of important cases, some acute.

Of great concern to public safety, it is also clear that coroners have been seriously concerned for several years about deteriorating ambulance responses and the role of related call handling and diversion services. Ambulance delays have cost lives and put the public at risk.

The effectiveness of the Department of Health's response to coroners' concerns is in question. The credibility of CQC's ratings on ambulance trusts is also challenged by the concerns that coroners have been repeatedly flagging. CQC's recent rating of an ambulance trust as 'Outstanding' is especially questionable when all are clearly operating in severely challenging conditions.

These concerns are underlined by the fact that Coroner's Section 28 reports represent only the tip of a safety iceberg.

Currently, there is no evidence of a systematic government approach to learning from the Section 28 reports. There is no published evidence of central analysis.

I have written to ask the Chief Coroner about:

- How many of the Section 28 reports issued so far have been published
- Missing responses from recipients of Section 28 reports
- Any government analysis that is taking place
- What happens if coroners are dissatisfied by Section 28 responses
- Possible improvements to the website for greater transparency.

The Department of Health, NHS regulators and other oversight bodies will be asked about their handling of Section 28 reports.

I should be very grateful and interested to hear from anyone who is aware of coroners' Section 28 reports that have been issued but have not been published.

INTRODUCTION

Coroners have a duty to investigate certain deaths and to determine how these happened. Thses are up to date House of Commons briefings on what coroners and the Chief Coroner do:

http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN03981

http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN05721

It is an imperfect system and heavily dependent on reporting.

Coroners may miss salient issues.

Powerful organisations with unlimited funds for legal services are more able to manipulate the system, and bereaved families may be disadvantaged by inequality of arms. [3] [4]

A number of reforms have been introduced. Debate and evaluation continues on how effective these are. [5] [6]

There is considerable regional variation in reporting to coroners, and variation between individual coroners' departments. [7]

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[3] How the inquest system fails bereaved people
http://www.inquest.org.uk/pdf/how_the_inquest_system_fails_bereaved_people.pdf

[4] Death certification and investigation in England Wales and Northern Ireland. The report of a fundamental review 2003.
http://webarchive.nationalarchives.gov.uk/20131205105739/http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf

[5] Reform of the coroners' system and death certification, Constitutional Affairs Committee, 1 August 2006
https://publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/902i.pdf

[6] Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009 Response to consultation on rules, regulations, coroner areas and statutory guidance. MoJ 4 July 2013
https://consult.justice.gov.uk/digital-communications/coroner-reforms/results/implementing-the-coroner-reforms-response.pdf

[7] Coroners Statistics Annual 2016 England and Wales

"When looking at the number of deaths reported to coroners in 2016 as a proportion of registered deaths21, which allow for some differences in population characteristics, there is still a wide variation across coroner areas e.g. 28% in East Lancashire compared to 96% in Stoke-on-Trent and North Staffordshire."

"The proportion of post-mortems carried out varies from 21% in North Lincolnshire and Grimsby to 62% in Isle of Wight."

"The proportion of inquests carried out varies from 8% in Stoke-on-Trent and North Staffordshire to 40% in North Tyneside."

https://www.gov.uk/government/statistics/coroners-statistics-2016

Of relevance, a national network of medical examiners to improve scrutiny of deaths and to detect poor care more promptly has been proposed by various public inquiries, and strongly supported by the Royal College of Pathologists. [8] [9] However, this has been repeatedly delayed. Controversially, the government announced a further delay earlier this year, with a new implementation deadline set for 2019. [10]

Nevertheless, for all the limitations, coroners' findings provide an important window into risks to public safety.

Of special interest are the warning reports that coroners issue on an exceptional basis when they consider that action needs to be taken to prevent future deaths.

Coroners previously had discretionary powers to issue a 'Rule 43' report under the Coroners Rules 1984 on matters arising from deaths they had reviewed which could cause a recurrence of similar fatalities. [11]

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[8] An overview of the death certification reforms. Department of Health May 2016 https://www.gov.uk/government/publications/changes-to-the-death-certification-process/an-overview-of-the-death-certification-reforms

[9] Medical Examiners. Royal College of Pathologists. May 2016 https://www.rcpath.org/discover-pathology/public-affairs/medical-examiners.html

[10] Statement by Royal College of Pathologists 30 March 2017 in response to further government delay https://www.rcpath.org/discover-pathology/news/medical-examiner-delay.html

[11] *"**43.** A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly.*

(a) a senior coroner has been conducting an investigation under this Part into a person's death,

(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

This power was used variably and was replaced with a statutory duty under Part 7 of Schedule 5 of the Coroners and Justice Act 2009. This conferred a wider duty to raise all matters discovered during investigation that could prevent a future risk to life, whether or not they had contributed to the death in question. Such reports are known as reports on action to prevent future deaths, or "PFDs". [12]

On receipt of a Section 28 report, recipients must provide the coroner with a written response, (a time limit of 56 days is given), and the coroner must send a copy of the Section 28 report and any responses to the Chief Coroner, who may publish them.

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(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner."

http://www.legislation.gov.uk/uksi/1984/552/contents/made

[12] Coroners and Justice Act 2009

"Action to prevent other deaths 7

(1) Where—
(a) a senior coroner has been conducting an investigation under this Part into a person's death,
(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.
(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner."

http://www.legislation.gov.uk/ukpga/2009/25/pdfs/ukpga_20090025_en.pdf

Recipients of Section 28 reports are often informed that they may make representations to coroners about whether their responses are published:

	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	**20th April 2017 (Re-issued)** **Alison Hewitt**

As far as I can see, there is no provision set out in the Chief Coroner's guidance [13] for circumstances where the recipients of Section 28 reports fail to respond to coroners. This seems a significant system weakness. It seems an odd process of justice where matters can simple fizzle out, beyond the public eye.

I can see no explanation from the Chief Coroner on how decisions are made with regards to whether Section 28 reports and responses are published or not published.

Again, this seems an omission in the face of the principle that justice must be seen to be done.

Section 28 reports are issued only in a small number of inquest cases.

Due to data missing from the Chief Coroner's annual reports on the number of Section 28 reports that have been issued since they were introduced, it is not possible to say definitively what proportion of inquests have generated Section 28 reports since the latter were introduced in 2013.

[13] The Chief Coroner's guide to the Coroners and Justice Act 2009 https://www.judiciary.gov.uk/publications/the-chief-coroners-guide-to-the-coroners-and-justice-act-2009/

However, the most recent Chief Coroner's annual report seems to indicate that a decision was made in 2015/16 to start publishing all Section 28 reports:

Year	Number of inquest conclusions recorded	Chief Coroner's annual report on Section 28 reports
2013	31, 579	2013/14: "All reports (and responses) must now be sent to the Chief Coroner and they are published on the judiciary website. Some reports are selected to pursue further. All of that is new. And the Chief Coroner encourages coroners to write reports." **No figure given**.
2014	29,153	2014/15: "Since the publication of last year's Chief Coroner's report **504** Prevention of Future Death reports (paragraph 7(1) Schedule 5 to the 2009 Act) have been issued."
2015	35,473	2015/16: "These PFD reports - **571** in number in 2015 - are hugely important. They draw attention of government agencies, individuals and organisations to the fact that something has gone wrong and action should be taken… *Because of their importance the Chief Coroner decided to publish all PFD reports on the judiciary website (sometimes with redaction).* They are therefore made public and accessible to all who may have an interest in them. Email alerts are now available. For example, NHS England (London Region) has used this resource to identify learning from the deaths of vulnerable adults and children in healthcare settings across London."
2016	40,504	No data available yet

Source: Coroners' annual statistics and Chief Coroner's annual reports to the Lord Chancellor [14]

[14] Coroners' annual statistics and Chief Coroners annual reports

https://www.gov.uk/government/statistics/coroners-statistics-2013
https://www.gov.uk/government/statistics/coroners-statistics-2014
https://www.gov.uk/government/statistics/coroners-statistics-2015
https://www.gov.uk/government/statistics/coroners-statistics-2016
https://www.gov.uk/government/publications/chief-coroners-annual-report-2013-to-2014
https://www.gov.uk/government/publications/chief-coroners-annual-report-2014-to-2015
https://www.judiciary.gov.uk/publications/chief-coroners-annual-report-2015-16/

There appear to have been limited efforts to make systematic use of the data from coroner's warning reports. The Chief Coroner previously published periodic six monthly summaries on Rule 43 reports which provided brief summaries of coroners' concerns and details of the bodies involved. [15]

After the system changed from Rule 43 reports to Section 28 reports, the Chief Coroner published an initial summary report for the period 1 April 2013 to 30 September 2013, but no others seem to have followed.

> **https://minhalexander.files.wordpress.com/2016/09/april-2013-to-september-2013-summaryreportofpfdreportsapr-sep2013-10th.pdf**

I could find no other signs of recent analysis, in depth or otherwise, of warning reports.

[15] MoJ Summaries of Reports and Responses under Rule 43 of the Coroners Rules July 2008 to March 2013

https://minhalexander.files.wordpress.com/2016/09/july-2008-to-march-2009-summary-rule-43-v1.pdf
https://minhalexander.files.wordpress.com/2016/09/april-2009-to-september-summary-rule-43-v2.pdf
https://minhalexander.files.wordpress.com/2016/09/oct-2009-to-march-2010-third-summary-coroners-reports-rule43a.pdf
https://minhalexander.files.wordpress.com/2016/09/april-2010-to-oct-2010-rule-43-coroners-report-4th.pdf
https://minhalexander.files.wordpress.com/2016/09/oct-2010-to-march-2011-summary-rule-43-070312-5th.pdf
https://minhalexander.files.wordpress.com/2016/09/april-2011-to-september-2010-summary-rule-43-6th.pdf
https://minhalexander.files.wordpress.com/2016/09/oct-2011-to-march-2012-summary-rule-43-v7.pdf
https://minhalexander.files.wordpress.com/2016/09/april-2012-to-sept-2012-summary-rule-43-report-v8.pdf
https://minhalexander.files.wordpress.com/2016/09/oct-2012-march-2013-9th-rule-43-report.pdf

The charity INQUEST, in particular, has been critical of the resistance to learning from deaths in custody and mental health deaths, in which the same grievous errors are endlessly repeated despite very specific coroners' warnings. [16]

There is also a question of what happens when coroners are dissatisfied with the responses that they receive to their Section 28 reports. It appears that the trail ends until the next similar death, when the coroner makes reference to the past history and previous similar deaths.

DATABASE OF 4 YEARS OF CORONERS' SECTION 28 WARNINGS PUBLISHED UP TO 31 July 2017

Since July 2013 all Section 28 reports had to be sent to the Chief Coroner for possible publication.

Publication began in January 2014 when the then Chief Coroner Peter Thornton reportedly emphasised the importance of transparency:

"I place great emphasis on the valuable work of coroners in saving lives by highlighting risks which need to be eliminated. That is why publishing these reports and putting them into the public domain is so important." [17]

I have been following the chief coroner's publication of Section 28 reports for the last year.

I have found that reports, and responses to the reports, are uploaded somewhat erratically, sometimes with variable delays of months. A snapshot taken at any point in time is likely to be a significant underestimate of the reports that exist.

I have logged details of all published Section 28 reports up to of 31 July 2017 onto this downloadable database:

> **https://minhalexander.files.wordpress.com/2017/08/all-section-28-reports-on-action-to-prevent-future-deaths-published-by-chief-coroner-up-to-31-july-2017-pub.xlsx**

The database provides links to the individual published reports and any associated responses by persons to whom the reports were sent. Names of deceased, coroner's case reference numbers, coroners' categories of death and coroners' areas are also provided. This data can be searched.

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[16] http://inquest.org.uk/pdf/INQUEST_deaths_in_mental_health_detention_Feb_2015.pdf http://www.inquest.org.uk/pdf/reports/Learning_from_Death_in_Custody_Inquests.pdf

[17] https://www.crimeline.info/news/publication-of-reports-to-prevent-future-deaths

I have found the Chief Coroner's website user un-friendly for the following reasons:

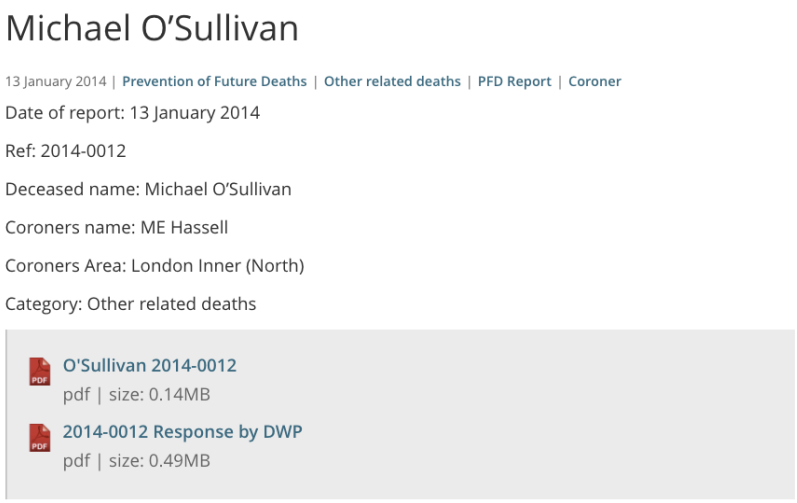
- The website is not searchable, unlike comparable websites operated by the Courts and Tribunals Judiciary

- Pages must be scrolled laboriously and slowly. Losing one's place requires starting again from square one, making searches a gargantuan task.

- It provides a flawed and misleading system of indexing where users are sign posted to categories of death which are in fact incomplete, because some cases are not corrected labelled and relevant cases are dispersed throughout other different categories.

  For example, there were 94 Section 28 reports about deaths determined to be suicides, but over half of these (54) were not labelled as such on the Chief Coroner's website. They would have been missed by any member of the public looking for deaths by suicide, unless they systematically scrolled through the whole database.

  For example, a much reported and important Section 28 report on a DWP related suicide, the death of Michael O'Sullivan, was filed under 'Other related deaths':



"CIRCUMSTANCES OF THE DEATH

I found that the trigger for Mr O'Sullivan's suicide was his recent assessment by a DWP doctor as being fit for work."

https://www.judiciary.gov.uk/publications/michael-osullivan/

This case and a few other mislabelled suicides could be accounted for by the fact that the category of 'suicide' was not introduced by the chief coroner's office until 2015. However, this does not account for many mislabelled Section 28 reports which were issued in 2015 and after.

Conversely, a few deaths were labelled as suicides when the Section 28 reports gave no indication of specific intent or even explicitly stated that no specific intent had been proven.

This is the list of published Section 28 reports on suicides, showing which reports were correctly labelled and which were obscured:

https://minhalexander.files.wordpress.com/2016/09/section-28-reports-on-deaths-by-suicide-published-by-chief-coroner-up-to-31-july-2017.xlsx

In addition to suicides, other important examples of mislabelled deaths included deaths in custody, police related deaths, service personnel deaths and construction industry deaths. [18]

In its current state, the Chief Coroner's website is not sufficiently accessible to the public. This is because it does not allow interrogation without extraordinary user effort, there is obfuscation of trends and systemic risks because of the way data is presented.

There is a risk that bereaved families may be denied answers.

Making the website searchable, including by free text and by different parameters such as dates, names of deceased, names of coroner, coroner area and category of deaths would increase accessibility and transparency.

GENERAL RESULTS

I found a total of 1725 Section 28 reports by coroners in England and Wales published up to 31 July 2017, relating to the deaths of 1799 people. The earliest of the reports had been issued on 30 July 2013.

The Section 28 reports related to the deaths of at least 1142 males and 646 females (data on gender was missing in a few cases).

[18] Examples of important cases that were mislabelled or incompletely cross referenced included: **Duggan** 2014-0182 filed under 'Other related deaths', **Cunningham** 2014-0087 filed under 'Product related deaths', **Overy** 2014-0535 filed under 'Other related deaths', **Dalrymple** 2014-0410 filed under 'Other related deaths' **Mc Glasson** 2014-0001 a construction industry death filed under 'Alcohol, drug and medication related deaths"

There at least 175 child deaths (defined as age below eighteen).

At least 350 Section 28 reports related to self-inflicted deaths [18b], with a specific finding of suicide indicated in 94 of the reports.

70 of the published Section 28 reports related to deaths in State custody, which occurred mostly in prisons but also in police custody, immigration centres and secure psychiatric units.

60 of the published Section 28 reports related to cases in which inquests had made findings of neglect, although in one case neglect was noted but was not considered to have contributed to the death.

One case of neglect, the death of Ivy Atkin a care home resident, was so gross that an inquest made a finding of unlawful killing. She reportedly lost almost half her body weight in 48 days and was discovered close to death with an infected pressure sore. There was an accompanying criminal conviction of manslaughter against the care home owner. The regulator, CQC, was criticised for failings. [19]

Shamefully, eight of the published 60 cases of neglect (13.3%) related to State detention. Four out of eight of these custody cases primarily involved private providers. [20]

[18b] I have used the classification of self inflicted death, as used for custody deaths, which encompasses both deaths in which intent of suicide is clear beyond reasonable doubt and other instances where people died by their own hands but definite suicidal intent was not found, or where recklessness and misadventure were considered to be more likely.

[19] Nottingham care home boss jailed for manslaughter, BBC 6 February 2016 http://www.bbc.co.uk/news/uk-england-nottinghamshire-35499865

[20] Custody deaths with neglect findings - case reference details:

The detained patients died in prison, an immigration centre, under the Mental Health Act and Deprivation of Liberty Safeguards. **Peter Barnes** Cygnet Hospital Ref. 2013-0291, **Shalane Blackwood** HMP Nottingham Ref. 2016 – 0179, **Kingsley Burrell** Birmingham and Solihull Mental Health NHS Trust Ref. 2015-0472, **Brian Dalrymple** Harmondsworth Immigration Removal Centre GEO Group UK Ltd (formerly G4S) Ref. 2014-0410, **Dale Proverbs** MHA Partnerships in Care Ref. 2015-0010, **Christopher Royal** Baron's Park Nursing Home Ref. 2014-0354, **Dean Saunders** HMP Chelmsford Ref. 2017-0056**, Richard Walsh** HMP Belmarsh Ref. 2016-0377

The bulk of the neglect cases related to the NHS. There were a number of 'repeat offender' trusts. Pennine Acute NHS Trust received four Section 28 reports in deaths where there had been a finding of a neglect. [21]

This is the full list of the 60 published cases where neglect had been found:

> **https://minhalexander.files.wordpress.com/2016/09/section-28-reports-with-findings-of-neglect-published-up-to-31-july-20171.xlsx**

Responses

There were no published responses at all to 1070 of the 1725 (62%) coroners' Section 28 reports.

There were no published responses for 43 of the 70 (61%) section 28 reports on deaths in State custody, when one might imagine that this is a key area for accountability and transparency.

There were also no published responses to 32 of the 60 (53.3 %) Section 28 reports on deaths were a finding of neglect had been made.

Where responses were published, there was not always a full set of responses from all the parties who had been sent Section 28 reports as a named respondent for action to prevent future death.

Particularly worrying was a lack of consistent published responses by government departments and oversight bodies.

For example, there no responses to 60 out of 172 Section 28 reports sent to the Department of Health for action to prevent future deaths.

There were no responses to 45 out of 100 Section 28 sent personally to the Secretary of State for Health for action to prevent future deaths.

We therefore do not know what action, if any, Jeremy Hunt proposed to take in response matters such as:

- Concerns about continuing Never Events and poor governance at North Cumbria University Hospitals NHS Trust, one of the so-called 14 'Keogh' trusts

[21] Pennine Acute Hospital NHS Trust deaths with findings of neglect:

Ref. 2017-0063, **Colin Moulton** 10 July 2015 Ref. 2015-0267, **Dominic Smith** 30 June 2016 Ref. 2016-0240, **Milly Zemmel** 6 April 2016 Ref. 2016 – 0139, Ref 2014-0421**, Kathleen Cooper** 8 March 2017

https://www.judiciary.gov.uk/publications/amanda-coulthard/

- Concerns about risk to life from a national shortage of radiologists

> Section 28 report, Ref. 2016-0491, 12 May 2016 on death of **Constance Pridmore** under the care of University Hospitals of Morecambe Bay NHS Foundation Trust:
>
> > *"…presently there are **400** vacant unfilled consultant radiologist posts unfilled in the UK…It is probable that current delays on both a local and national basis in obtaining in a timely manner, accurate radiologist reports of x-rays and CT scans taken for diagnostic purposes, creates a foreseeable risk that further deaths may well arise as a consequence."*

https://www.judiciary.gov.uk/wp-content/uploads/2014/11/Nelson-2014-0397.pdf
https://www.judiciary.gov.uk/wp-content/uploads/2017/03/Pridmore-2016-0491.pdf

- Concerns about risk to life from flawed ambulance call handling and algorithms
https://www.judiciary.gov.uk/publications/keith-ruston/
https://www.judiciary.gov.uk/wp-content/uploads/2015/07/Lester-2015-2015-0204.pdf

- Concerns about risk to life from persistent lack of acute mental health beds
https://www.judiciary.gov.uk/publications/george-taylor/

- Concerns about risk to life from lack of patient education about insulin pumps
https://www.judiciary.gov.uk/wp-content/uploads/2017/02/Thornton-2017-0030-1.pdf

Moreover, coroners sent 47 Section 28 reports to the health and social care watchdog, the Care Quality Commission (CQC) for action to prevent future deaths, but there were no published responses by CQC to 33 of these reports [see sheet 2 of the main database], eight of which related to deaths in which a finding of neglect had been made. [22]

[22] **Section 28 reports sent to CQC for action to prevent future death, in cases where there had been a finding of neglect, with no published CQC response to the coroner:**

The CQC is in fact a special case because it has a memorandum of understanding with the Coroners' Society [23] which ensures that it receives copies of all Section 28 reports, and is thus theoretically in a position to track and act upon the intelligence that coroners provide. There are signs that the CQC fails to do so and is not open about its activities. [24]

The lack of audit trail on responses to Section 28 reports and action taken to prevent future deaths is both of concern and surprising, as the past summary reports on the old Rule 43 arrangements [15] recorded that coroners almost always received responses to their reports.

Questions arise about whether the response rate has deteriorated, or alternatively, why the responses to Section 28 reports are not being published and whether this is justifiable.

The lack of transparency and public accountability runs counter to the accepted principle that justice should be seen to be done.

To give a specific example, there was no published CQC response to a Section 28 report on Ivy Atkin's above death due to unlawful killing from gross neglect.

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https://www.judiciary.gov.uk/publications/ivy-atkin/ (The CQC's response to the coroner was published some after 11 August 2017 when the failure to publish had been pointed out).
https://www.judiciary.gov.uk/publications/dorothy-clarkson/
https://www.judiciary.gov.uk/publications/edwin-thompson/
https://www.judiciary.gov.uk/publications/barbara-cooke/
https://www.judiciary.gov.uk/publications/crittall-mr/
https://www.judiciary.gov.uk/publications/beryl-farmer/
https://www.judiciary.gov.uk/publications/crittall-mr/
https://www.judiciary.gov.uk/publications/tommi-ray-vigrass/

[23] Memorandum of understanding between CQC and Coroners Society of England and Wales
https://minhalexander.files.wordpress.com/2016/09/mou_cqc_and_csocew_final.pdf

[24] https://minhalexander.com/2016/11/11/coroners-warnings-terminal-inexactitude-and-cqc-opacity/

https://minhalexander.com/2016/10/08/care-home-deaths-and-more-broken-cqc-promised/

https://minhalexander.com/2016/09/25/letter-9-september-2016-to-david-behan-cqc-chief-executive-on-cqc-under-reporting-of-coroners-mental-health-deaths-warnings/

I subsequently questioned the CQC about this on 11th August 2017. By 14th August 2017, CQC's response appeared on the Chief Coroner's website. It was dated 21 March 2017. The CQC's response to the coroner showed that CQC had essentially declined to rectify the central issue about which the coroner had raised a concern. [25]

Serious questions arise about why CQC's response was not published sooner, and whether it would it have been published it all if no enquiry had been made.

If responses are not published, they cannot be challenged.

NUMBERS OF SECTION 28 REPORTS

From the **summary reports** [15] previously published by the Chief Coroner, this was the distribution of the old Rule 43 reports in time:

Reporting period	**Number of Rule 43 reports issued**
17 July 2008 – 31 March 2009 (eight months)	207
1 April 2009 – 30 September 2009	164
1 October 2009 – 31 March 2010	195
1 April 2010 – 30 September 2010	175
1 October 2010 – 31 March 2011	189
1 April 2011 – 30 September 2011	210
1 October 2011 – 31 March 2012	233
1 April 2012 – 30 September 2012	186
1 October 2012 – 31 March 2013	235
Total period 17 July 2008 to 31 March 2013	**1794**

[25] The coroner was concerned about a legal loophole, which combined with CQC's interpretation of its duties, left small providers in charge of scrutinising their own DBS compliance. In the case of Ivy Atkin this loophole allowed a care home manager with a conviction for violence to operate as a 'Nominated Individual'. The coroner asked CQC to review this loophole. In its response to the coroner's Section 28 report, CQC declined to seek changes to the regulatory arrangements.

This gives an average rate of 384 warning reports a year.

A spreadsheet was also previously disclosed under FOI and gave similar information. [26]

The single, initial summary report on Section 28 reports that was published by the current Chief Coroner showed that there were 244 Section 28 reports issued in the six months between 1 April 2013 to 30 September 2013. [27]

Based on coroners' Section 28 reports published so far, the numbers of warning reports do not appear to have increased greatly overall since the switch from Rule 43 reports to Section 28 reports.

This is despite the discretionary reporting power changing to a statutory duty, and the scope for reporting increasing.

The average annual rate under the new Section 28 arrangements has been 430 reports, assuming that most reports are published, but clarification is needed on what proportion of reports have been published.

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[26] For completeness, this was a spreadsheet on coroners' Rule 43 reports disclosed via the What do they know website:

https://minhalexander.files.wordpress.com/2016/09/foi-data-what-do-they-know-all-9-summaries-of-rule-43-2010-to-2013.xlsx

It gave an average annual rate of 405 Rule 43 reports a year, distributed as follows:

	Number of Rule 43 reports issued by coroners in England and Wales
1 December 2009 to 31 March 2010 (four months)	113
Financial year 2010/11	367
Financial year 2011/12	449
Financial year 2012/13	420
Total period from 1 December 2009 to 31 March 2013	**1349**

NB Two Rule 43 reports dated 2003 and undated entries were excluded from the above analysis

[27] https://minhalexander.files.wordpress.com/2016/09/april-2013-to-september-2013-summaryreportofpfdreportsapr-sep2013-10th.pdf

Period	Number of all Section 28 reports published
30 July 2013 – 31 March 2014	309
2014/15	528
2015/16	400
2016/17	439
2017/18 year to 31 July 2017	49*
Total period (30 July 2013 to 31 July 2017)	**1725**

*This last figure in particular will be an underestimate of Section 28 reports issued because of the lag in publication.

Source: Chief Coroner's website

AUSTERITY AND DECENCY

Some Section 28 reports were disturbing in terms of what they implied about our times. For example:

1) As above, **Michael Sullivan** killed himself after being found fit to work by the DWP without regard to medical evidence from those treating him:

   "However, the ultimate decision maker (who is not, I understand, medically qualified) did not request and so did not see any reports or letters from Mr O'Sullivan's general practitioner (who had assessed him as being unfit for work), his psychiatrist or his clinical psychologist."

   https://www.judiciary.gov.uk/publications/michael-osullivan/

2) **Nathaniel Phillips**, a young man, died of acute asthma. The coroner found that he could not afford prescriptions and precariously relied on asthma medication prescribed for other family members.

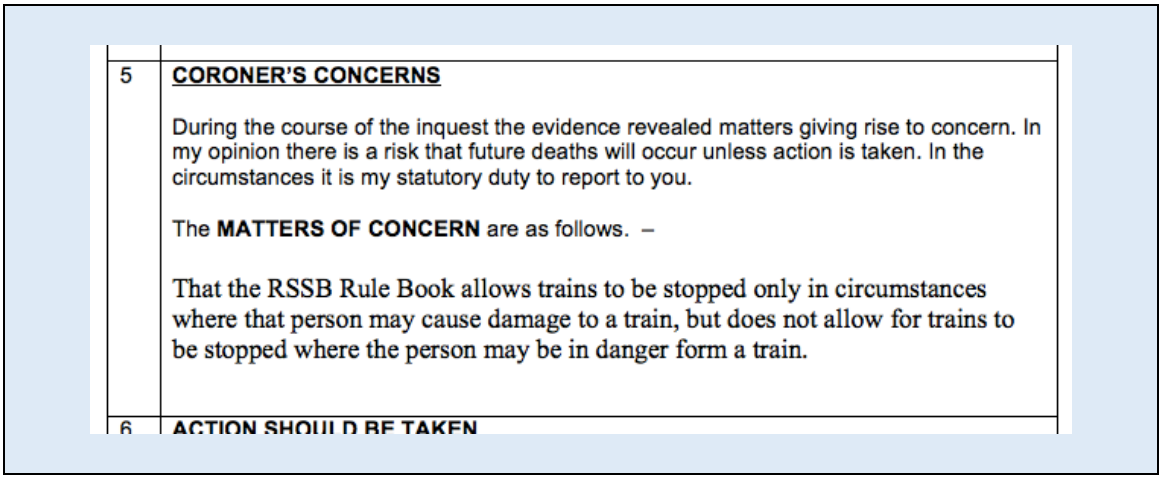
   There was no response from the Department of Health to the coroner's suggestion that asthma medications should be added to the list of medicines exempted from prescription charges.

   https://www.judiciary.gov.uk/publications/nathaniel-phillips/

3) **Malcolm Burge** a retired gardener with no history of debt set himself on fire after Newham Council pursued him for a debt of £800.69 that arose from over payment of housing benefit and council tax benefit.

https://www.judiciary.gov.uk/publications/malcolm-burge/

4) In a number of railway deaths (**Lewis Ghessen** 9 June 2015, **Michael Bovell** 29 June 2015, **Lauris Kodors** 13 September 2016) coroners noted that RSSB rules allow train drivers to stop if a person on the tracks might damage a train, but not vice versa.



5	**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. – That the RSSB Rule Book allows trains to be stopped only in circumstances where that person may cause damage to a train, but does not allow for trains to be stopped where the person may be in danger form a train.
6	**ACTION SHOULD BE TAKEN**

https://www.judiciary.gov.uk/publications/lewis-ghessen/
https://www.judiciary.gov.uk/publications/michael-bovell/
https://www.judiciary.gov.uk/publications/lauris-kodors/

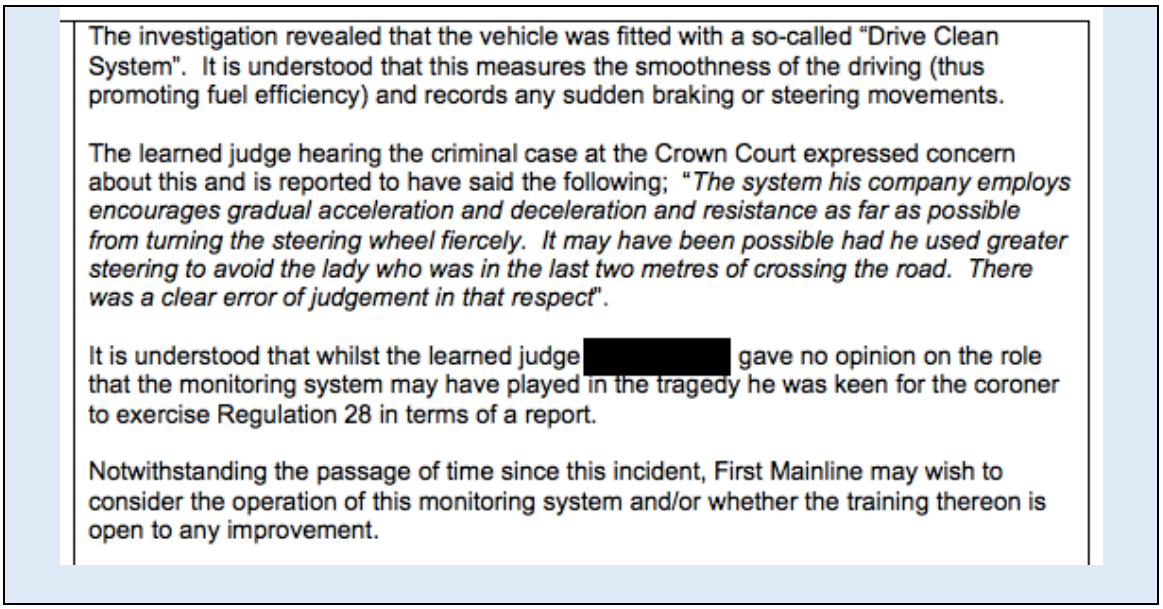
5) The accidental death of **Garrett Elsey** who sheltered in a commercial waste bin overnight. The coroner's section 28 report revealed that not only does our society need rules to prevent injuries to people who sleep in bins, but that these are not always followed.

https://www.judiciary.gov.uk/publications/elsey-2013-0316/

Health and Safety Executive 25:

https://minhalexander.files.wordpress.com/2016/09/hse-waste25-people-in-commercial-waste-containers.pdf

6) The death of **Sheila Bowling** who was knocked down by a bus revealed that the bus company operated a system of driving which involved minimal acceleration, braking and sharp turns. This saves on fuel.



The investigation revealed that the vehicle was fitted with a so-called "Drive Clean System". It is understood that this measures the smoothness of the driving (thus promoting fuel efficiency) and records any sudden braking or steering movements.

The learned judge hearing the criminal case at the Crown Court expressed concern about this and is reported to have said the following; "*The system his company employs encourages gradual acceleration and deceleration and resistance as far as possible from turning the steering wheel fiercely. It may have been possible had he used greater steering to avoid the lady who was in the last two metres of crossing the road. There was a clear error of judgement in that respect*".

It is understood that whilst the learned judge [redacted] gave no opinion on the role that the monitoring system may have played in the tragedy he was keen for the coroner to exercise Regulation 28 in terms of a report.

Notwithstanding the passage of time since this incident, First Mainline may wish to consider the operation of this monitoring system and/or whether the training thereon is open to any improvement.

https://www.judiciary.gov.uk/publications/sheila-bowling/

CORONERS' FIRE SAFETY WARNINGS BEFORE GRENFELL

After the recent Grenfell tower fire, it was revealed that there had been a previous fatal incident at Lakanal House, which was also a council owned block with major fire safety faults. A scandal arose about government failure to take sufficient action after the Lakanal house incident and a related coroner's warning. [28] [29]

Apropos concerns that a faulty Hotpoint fridge freezer may have triggered the Grenfell blaze, it was also revealed that there had been prior concerns raised about fires started by fridge freezers. [30]

General questions have arisen about other housing stock, and public buildings such as hospitals and prisons, and whether deregulation has led to cost cutting on safety measures such as sprinklers.

[28] https://www.theguardian.com/uk-news/2017/feb/28/southwark-council-fined-570000-over-fatal-tower-block-fire

[29] https://www.theguardian.com/uk-news/commentisfree/2017/jun/19/grenfell-tower-lakanal-house-inquest-fire-safety

[30] London Fire Service statement about risks posed by fridge freezers 3 March 2015 http://www.london-fire.gov.uk/news/LatestNewsReleases_Fridgefreezerdelayputtinglivesatrisk.asp#.WZp2KZOGOgQ

A public inquiry into Grenfell is now underway.

This is the coroner's Rule 43 documentation on the Lakanal House fire, with key responses:

https://minhalexander.files.wordpress.com/2016/09/lakanal-house-ec-letter-to-dclg-pursuant-to-rule43-28march2013.pdf

https://minhalexander.files.wordpress.com/2016/09/lakanal-house-ec-letter-to-london-borough-southwark-pursuant-to-rule43-28march2013.pdf

https://minhalexander.files.wordpress.com/2016/09/lakanal-house-ec-letter-to-london-fire-brigade-pursuant-to-rule43-28march2013.pdf

https://minhalexander.files.wordpress.com/2016/09/lakanal-house-ec-letter-from-rt-hon-eric-pickles-mp-20may2013.pdf

https://minhalexander.files.wordpress.com/2016/09/lakanal-house-ec-london-borough-southwark-letter-response-to-rule-43-23may2013.pdf

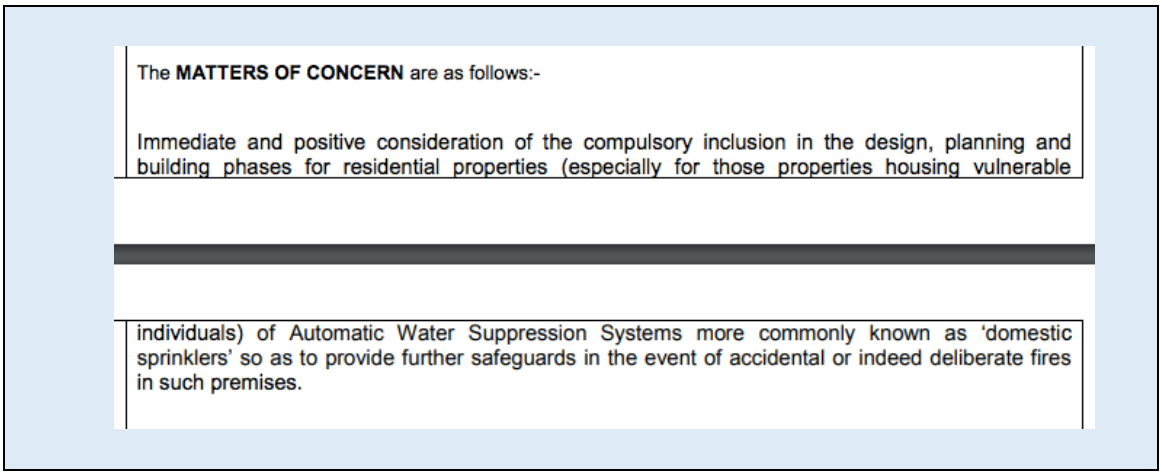
https://minhalexander.files.wordpress.com/2016/09/lakanal-house-ec-london-fire-brigade-response-to-coroners-rule43-report-23may2013.pdf

In the last four years, before the Grenfell deaths, there have been twenty coroners' Section 28 reports published on fire related deaths.

These Section 28 reports have included matters such as the need to ensure that sprinklers and smoke alarms are installed in housing stock, especially for vulnerable people with reduced mobility or at greater risk of causing fires, issues about emergency response and cuts to fire services and the risk of fire presented by Hotpoint fridge freezers because of a flammable insulant that can act as a fire accelerant.

Some of the cases are as follows:

1. Death of **Emma Waring** a vulnerable adult. The coroner advised that regulations should be amended to include installation of sprinklers especially in housing for vulnerable people. There was no published response by the Department for Communities and Local Government.



The **MATTERS OF CONCERN** are as follows:-

Immediate and positive consideration of the compulsory inclusion in the design, planning and building phases for residential properties (especially for those properties housing vulnerable

[redacted]

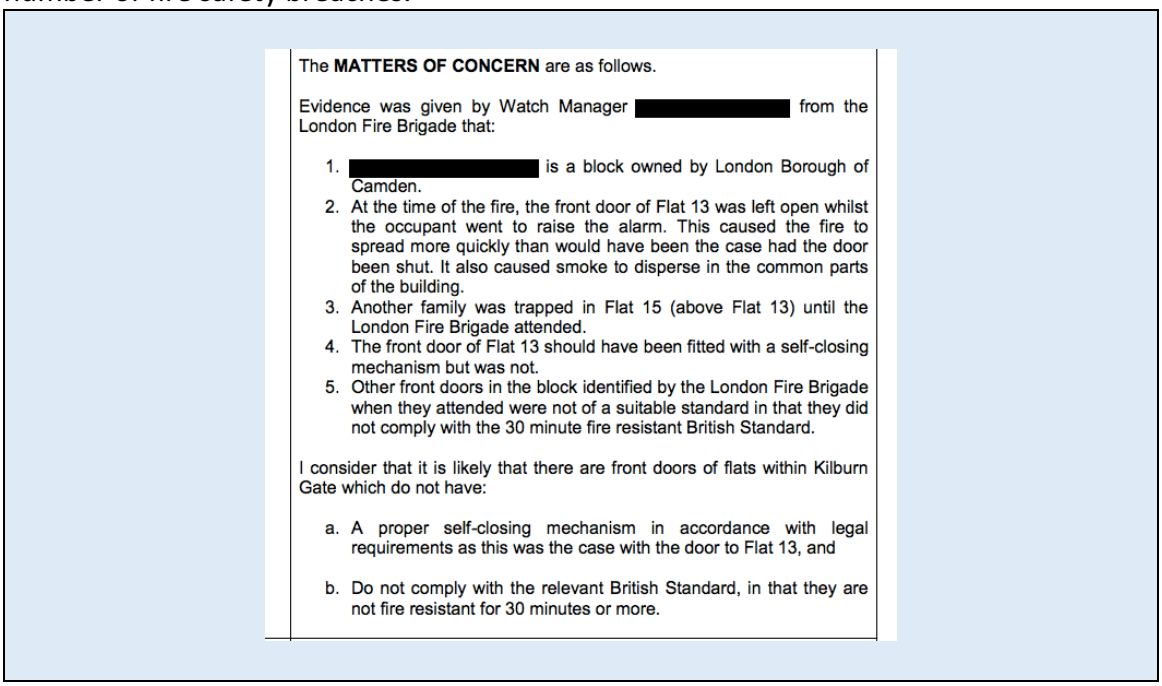
individuals) of Automatic Water Suppression Systems more commonly known as 'domestic sprinklers' so as to provide further safeguards in the event of accidental or indeed deliberate fires in such premises.

https://www.judiciary.gov.uk/publications/emma-waring/

2. Unlawful killing of **Stephen Hunt** a fireman related to an incident of arson, in which the coroner made a detailed finding about Fire Service operations with national implications, addressed to Theresa May as the then Home Secretary. There was no published response by the Home Office.

   http://www.manchestereveningnews.co.uk/news/greater-manchester-news/stephen-hunt-inquest-jury-finds-11350611
   http://www.manchestereveningnews.co.uk/news/greater-manchester-news/stephen-hunt-inquest-jury-finds-11350611

3. Death of **Ellen Kelly** in a Camden Council block of flats, in which the coroner found a number of fire safety breaches.



The **MATTERS OF CONCERN** are as follows.

Evidence was given by Watch Manager [redacted] from the London Fire Brigade that:

1. [redacted] is a block owned by London Borough of Camden.
2. At the time of the fire, the front door of Flat 13 was left open whilst the occupant went to raise the alarm. This caused the fire to spread more quickly than would have been the case had the door been shut. It also caused smoke to disperse in the common parts of the building.
3. Another family was trapped in Flat 15 (above Flat 13) until the London Fire Brigade attended.
4. The front door of Flat 13 should have been fitted with a self-closing mechanism but was not.
5. Other front doors in the block identified by the London Fire Brigade when they attended were not of a suitable standard in that they did not comply with the 30 minute fire resistant British Standard.

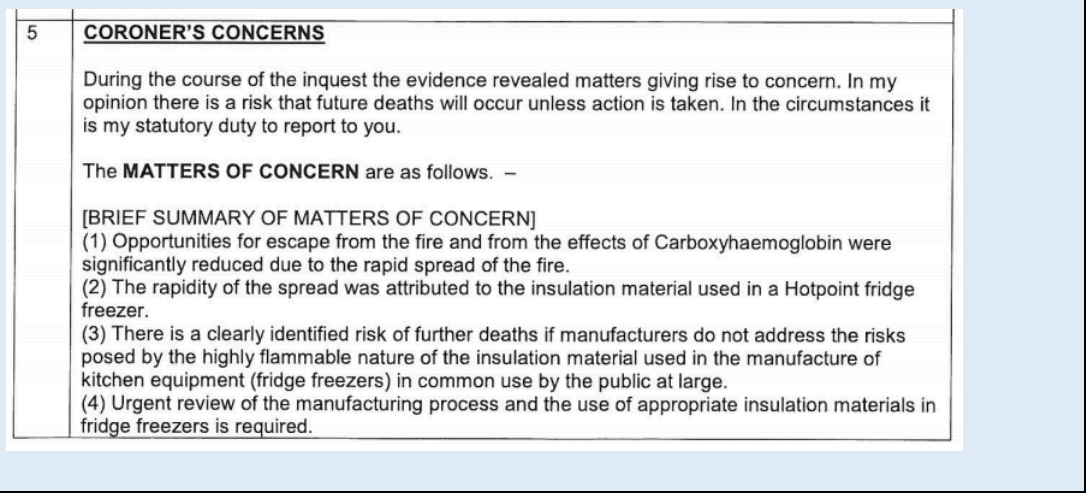
I consider that it is likely that there are front doors of flats within Kilburn Gate which do not have:

a. A proper self-closing mechanism in accordance with legal requirements as this was the case with the door to Flat 13, and

b. Do not comply with the relevant British Standard, in that they are not fire resistant for 30 minutes or more.

https://www.judiciary.gov.uk/publications/ellen-kelly/

4. Death of **Anthony Lapping** after a domestic fire despite rapid rescue, because of a large amount of carbon monoxide due to acceleration of the fire by the insulation material in his Hotpoint fridge freezer. The coroner recommended on 8 May 2014 that the manufacturing process should be urgently reviewed. There was no published response from the manufacturer.



5	**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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Opportunities for escape from the fire and from the effects of Carboxyhaemoglobin were significantly reduced due to the rapid spread of the fire. (2) The rapidity of the spread was attributed to the insulation material used in a Hotpoint fridge freezer. (3) There is a clearly identified risk of further deaths if manufacturers do not address the risks posed by the highly flammable nature of the insulation material used in the manufacture of kitchen equipment (fridge freezers) in common use by the public at large. (4) Urgent review of the manufacturing process and the use of appropriate insulation materials in fridge freezers is required.

https://www.judiciary.gov.uk/publications/anthony-lapping/

5. Death of Santosh Muthiah due to a fire caused by a Beko fridge freezer. The coroner identified a lack of systematic information gathering about appliances which caused fires and made suggestions for better learning from fires, including marking appliances in such a way that would survive a fire to allow identification after incidents.

   https://www.judiciary.gov.uk/publications/santosh-muthiah/

   This is the response from the government:

   https://www.judiciary.gov.uk/wp-content/uploads/2014/11/2014-0476-Response-by-Department-for-Business-Innovation-Skills.pdf

6. Death of **Amanda Richards** a wheelchair bound person in which the coroner suggested sprinklers should be installed in properties with vulnerable people.
   https://www.judiciary.gov.uk/publications/amanda-richards/

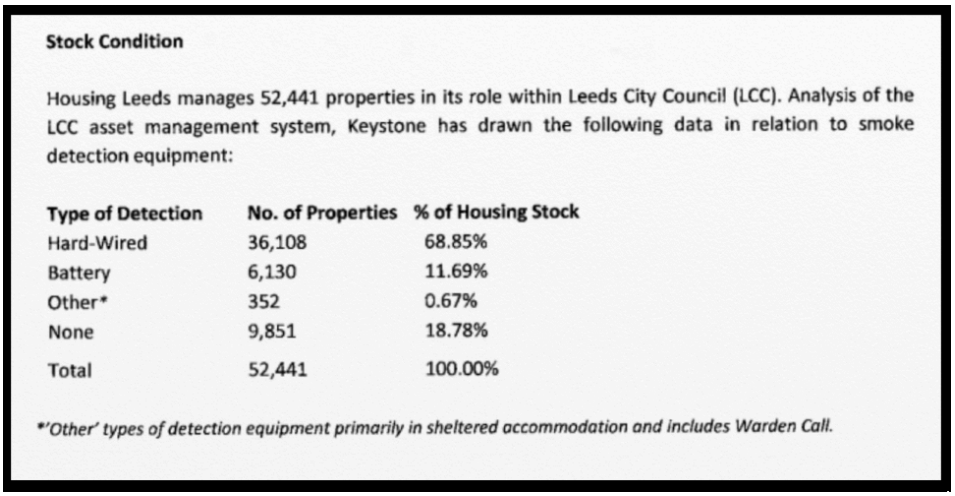
7. Death of **Jack Sheldon** in which the coroner noted problems with the management of multiple calls about the same incident and prioritisation of appliance

   https://www.judiciary.gov.uk/publications/jack-sheldon/

8. Death of **Kenneth Bailey** in which the coroner noted reports from local residents that due to very part time opening hours of a local fire station, the fire service response was not as fast as it used to be.

   https://www.judiciary.gov.uk/publications/kenneth-bailey/

9. Death of Julie Ann Camm a vulnerable adult with schizophrenia who died by her own hand, setting a fire in the process. The coroner expressed concern about the lack of smoke alarms in her rented property. Leeds Council provided audit information showing that 18.78% of the housing stock still needed smoke alarms and committed to 100% installation.



Stock Condition

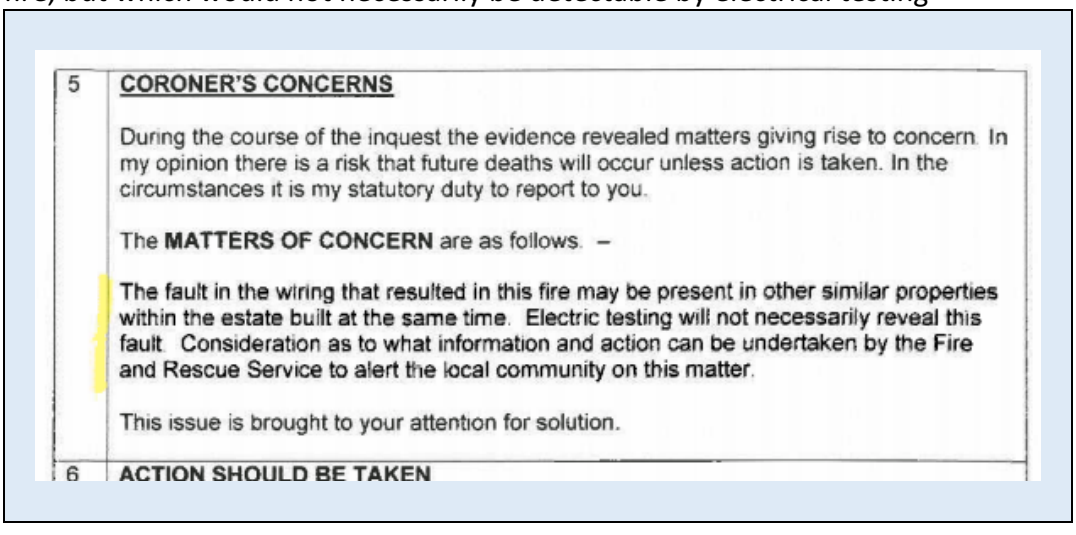
Housing Leeds manages 52,441 properties in its role within Leeds City Council (LCC). Analysis of the LCC asset management system, Keystone has drawn the following data in relation to smoke detection equipment:

Type of Detection	No. of Properties	% of Housing Stock
Hard-Wired	36,108	68.85%
Battery	6,130	11.69%
Other*	352	0.67%
None	9,851	18.78%
Total	52,441	100.00%

*'Other' types of detection equipment primarily in sheltered accommodation and includes Warden Call.

   https://www.judiciary.gov.uk/publications/julie-ann-camm/

10. Death of **Christopher Butler** revealed a construction fault that led to a fatal electrical fire, but which would not necessarily be detectable by electrical testing



5 **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 fault in the wiring that resulted in this fire may be present in other similar properties within the estate built at the same time. Electric testing will not necessarily reveal this fault. Consideration as to what information and action can be undertaken by the Fire and Rescue Service to alert the local community on this matter.

This issue is brought to your attention for solution.

6 **ACTION SHOULD BE TAKEN**

   https://www.judiciary.gov.uk/publications/christopher-butler/

11. Death of **Frazer Livesey** who was unable to escape from a fire due to expanding door and window seals

    https://www.judiciary.gov.uk/publications/frazer-livesey/

NHS SAFETY

I will provide some broad results below and in the next section I provide a more detailed report on NHS ambulance services.

The NHS featured in at least 57.2% of all Section 28 reports published so far (987 out of 1725), often centrally.

This is an underestimate as the Section 28 reports did not always contain enough information to clearly confirm or exclude whether an NHS body was implicated in the failings and hazards at issue, and further research would likely identify a higher proportion of NHS cases.

NHS failure in cases of deaths in custody was especially hard to clearly establish from Section 28 reports because of the multiplicity of organisations involved and poor, opaque CQC registration data on health providers for prisons and kindred.

There were no published responses to 61.4% (607 of 987) of the NHS Section 28 reports.

71 of the published Section 28 reports related to the Welsh NHS and 916 Section 28 reports related to the English NHS.

A number of NHS bodies have been the subject of numerous repeated Section 28 reports.

For example, there were 21 published Section 28 reports which related to Brighton and Sussex University Hospitals NHS Trust between February 2014 and April 2017.

Nineteen of these reports had been copied to the Secretary of State.

The CQC placed this trust into special measures after the fifteenth Section 28 report.

The coroner's frustration at lack of action to ameliorate risks is palpable from the warning reports issued.

Other examples included:

- Stockport NHS Foundation Trust (twenty Section 28 reports)
- Tameside Hospital NHS Foundation Trust (nineteen Section 28 reports)
- Barts Health NHS Trust (seventeen Section 28 reports)

- Pennine Acute NHS Trust (sixteen Section 28 reports)
- Sussex Partnership NHS Foundation Trust (thirteen Section 28 reports)
- Norfolk and Suffolk NHS Foundation Trust (twelve Section 28 reports)

The reference details of the relevant Section 28 reports are listed here:

https://minhalexander.files.wordpress.com/2016/09/examples-of-nhs-trusts-which-have-been-subject-to-repeated-coroners_-section-28-reports-for-action-to-prevent-future-deaths2.pdf

Some of CQC's flagship 'Oustanding' trusts have also been subject to repeated Section 28 reports, some recent, for example Salford Royal NHS Foundation Trust and West Midlands Ambulance Service:

Coroner's Section 28 reports published on Salford Royal NHS Foundation Trust up to 31 July 2017:

1	Gordon Arthur, Ref. 2017-0009, issued 2 February 2017
2	Paul Ashton, Ref. 2014-0170, issued 14 April 2014
3	Daniel McCallum Keane, Ref. 2014-0260, issued 9 June 14
4	Martin Deane, Ref. 2014-0416, issued 22 September 2014
CQC rated Salford Royal NHS Foundation Trust 'Outstanding on 27 March 2015 *"The concept of providing safe, harm free care was considered as a priority by all members of staff."*	
5	Stanley Oliver, Ref. 2015-0281, issued 16 July 2015
6	Wendy Thorne, Ref. 2016-0408, issued 11 November 2016
7	Natalie Thornton, Ref. 2017-0030, issued 6 February 2017
8	Katherine Derbyshire, Ref. 201, 7-0199, issued 16 June 2017

Coroner's Section 28 reports published on West Midlands Ambulance NHS Foundation Trust up to 31 July 2017:

1	Mary Waldron, Ref. 2014-0127, issued 10 January 2014
2	Caroline Crowther, Ref. 2014-0418, issued 24 September 2014
3	Kingsley Burrell, Ref. 2015-0472, issued 20 March 2015
4	Frederick White, Ref. 2015-0212, issued 3 June 2015
5	Caragh Melling, Ref. 2016 – 0167, issued 27 April 2016 In this case, WMAS acknowledged that its triage system did not detect agonal breathing (a sign of critical illness)
6	Jane Reason, Ref. 2016-0376, issued 25 October 2016

	In this case, WMAS' defibrillation equipment failed and a back up battery was flat.
7	Rex Hall, Ref. 2016-0422, issued 29 November 2016 In this case, the coroner found that WMAS paramedics were unable to read an ECG in order to tell if a patient had suffered a heart attack)
On 25 January 2017, CQC rated West Midlands Ambulance Service 'Outstanding' ***"Staff were competent in their roles and provided with timely appraisals and learning opportunities."***	

The numbers of published Section 28 reports on Welsh NHS Health Boards were as follows:

Welsh NHS Health Board	Number of published Section 28 reports up to 31 July 2017
Betsi Cadwaladr University Health Board	24 reports
Cwm Taf University Health Board	13 reports
Abertawe Bro Morgannwg University Health Board	10 reports
Cardiff and Vale University Health Board	9 reports
Hywel Dda University Health Board	6 reports
Aneurin Bevan University Health Board	6 reports
Powys Teaching Health Board	1 report

These are the relevant case references for Welsh health boards:

https://minhalexander.files.wordpress.com/2016/09/section-28-reports-relating-to-welsh-nhs-health-boards-published-by-the-chief-coroner-up-to-31-july-2017.pdf

I should stress again that these figures are based on only on *published* reports, and that clarification is needed on the actual number of reports issued.

Also, organisations may sometimes have lower number numbers of coroners' warnings despite safety concerns. For example, Southern Health NHS Foundation Trust attracted only a handful of coroners' warning reports in the period in which hundreds of deaths were not properly reviewed. [31]

[31] The Mazars deaths review of Southern Health NHS Foundation Trust reported that there were 375 inquests on trust patients during the period covered by the review (April 2011 to March 2015) – page 174:

The data will need further examination and cross checking with other sources. My broad impression of it so far is that it unsurprisingly shows strain on the service, with instances of disorganisation and error, as well as number of coroners' remarks about lack of resources and understaffing.

For example, in the death of a patient from infection after surgery, the coroner noted that staff had reported that they were overwhelmed due to understaffing and that this was not unusual:

> ***"The first matter of concern was that three witnesses who gave evidence, two Senior Nurses and one Doctor, told me that on the night that Sara died there were insufficient members of staff available to deal with the caseload of patients and this was not unusual. They felt overwhelmed and yet unable to escalate the care"***
>
> https://www.judiciary.gov.uk/publications/sari-keen/

There were signs of failure to learn by the NHS, and sometimes the 'matter of concern' was in fact failure to conduct serious incident investigations after deaths either properly or at all, or to act upon the recommendations from deaths investigations.

I was struck at how many of the Section 28 reports related to failures to deliver basic of care to older people – skin care, falls prevention, support with eating, and safe medicines management (especially of anticoagulants). Coroners sometimes drew explicit links between such care failings and understaffing. In some cases, falls and other harm occurred after a need for one to one care was identified but not delivered. Even where coroners made no specific findings about staffing, the nature of the unmet need itself raised questions of safe staffing.

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https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

According to Chief Coroner's data, during this period the trust was subject to one Rule 43 report and one Section 28 report.

To put a human face on the NHS Section 28 reports, here are a few striking cases:

Errol Mann died of pulmonary embolism after failure to ameliorate known risks. ITU staffing levels reportedly contributed to his death. A witness reported that there were persistent medical staff rota gaps, a key issue in the bitter dispute between the Secretary of State and the junior doctors. There was no published response from any party sent the Section 28 report for action to prevent future deaths.

https://www.judiciary.gov.uk/publications/errol-mann/

Dr John Davies died a lonely death by his own hand in a hotel room, with a finding by the coroner about the GMC's behaviour towards doctors who were the subject of complaints. There was no published response by the GMC to the Section 28 report.

https://www.judiciary.gov.uk/publications/john-davies/

Alva Jullien died of pneumonia due to 'recumbency' imposed upon her by delayed discharge from hospital for no good reason and despite the fact that her family would have been willing to care for her. She was made nil by mouth without sufficient evidence that this is was appropriate, and placed on the notorious Liverpool care pathway. There was no published response by Stockport NHS Foundation Trust to the Section 28 report.

https://www.judiciary.gov.uk/publications/jullien-2013-0232/

Mohammed Chaudhury suffered multiple injuries after a traffic collision and died of septic pressure sores of *'unusual in extent and severity'* which developed at Kings College Hospital NHS Foundation Trust. There was no published response from the trust or from Mike Richards, former CQC Chief Inspector to the Section 28 report.

https://www.judiciary.gov.uk/publications/mohammed-chaudhury/

Carol Gibson died of a fatal reaction to a drug which she had been prescribed for a fourth and final time in error by her GP practice, all after it had been flagged by hospitals services that she had suffered an earlier, serious adverse reaction to this drug. There was no published response by her GP surgery or by NHS England to the Section 28 report.

https://www.judiciary.gov.uk/publications/carol-ann-gibson/

PROPORTION OF CORONERS' WARNINGS ABOUT THE NHS

NHS deaths have always featured prominently in coroners' warnings, but there has been an increase in the proportion of NHS cases over time.

The increase started during the years when Rule 43 arrangements were in place:

Reporting period	Number of all Rule 43 reports issued	Number of Rule 43 reports issued about NHS hospitals and trusts
17 July 2008 – 31 March 2009 (eight months)	207	78 (37.6%)
1 April 2009 – 30 September 2009	164	65 (39.6%)
1 October 2009 – 31 March 2010	195	74 (37.9%)
1 April 2010 – 30 September 2010	175	72 (41.1%)
1 October 2010 – 31 March 2011	189	86 (45.5%)
1 April 2011 – 30 September 2011	210	106 (50.4%)
1 October 2011 – 31 March 2012	233	120 (51.55%)
1 April 2012 – 30 September 2012	186	102 (54.8%)
1 October 2012 – 31 March 2013	235	103 (43.8%)
Total period 17 July 2008 to 31 March 2013 (months)**	**1794**	**806 (44.9%)**

Source: Bi-annual Chief Coroner summaries on Rule 43 reports

Caution is needed in drawing conclusions from subsequent published Section 28 reports as they do not represent a complete dataset. Reports are almost certainly missing, especially for the last year or so, because of the lag effect in publication.

Rule 43 reports and Section 28 reports are also not fully comparable.

But for completeness, this has been the distribution over time of published coroners' Section 28 reports on the NHS (*including primary care*).

Period	Number of all Section 28 reports published	Number of Section 28 reports published about all NHS services including primary care
20 July 2013 – 31 March 2014	309	167 (54% of all reports)
2014/15	528	309 (58.5% of all reports)
2015/16	400	229 (57.2%of all reports)
2016/17	439	245 (55.8% of all reports)
2017/18 year to 31 July 2017	49	37 (75.5% of all reports)
Total period (20 July 2013 to 31 July 2017)	**1725**	**987 (57.2% of all reports)**

CORONERS' WARNINGS ABOUT AMBULANCE SERVICES AND RELATED MATTERS

The effectiveness of ambulance services matters to all. Ambulance performance is a matter of political sensitivity as are the controversial schemes for diverting patients to less acute forms of care, which some have criticised as a means of saving money and downgrading services. [32]

There are 10 English NHS ambulance trusts and one Welsh ambulance trust. They operate under great pressure. English national NHS staff survey returns for ambulance trusts show the highest levels of bullying out of all types of NHS trusts (average of 28% in 2016). Ambulance trusts also return very low scores on communication between staff and senior

[32] NHS to revamp 111 helpline after sustained criticism of service, Denis Campbell Guardian 8 March 2017
https://www.theguardian.com/society/2017/mar/08/nhs-to-revamp-111-helpline-after-sustained-criticism-of-service
National review of schemes to divert patients from A&E amid safety fears, Laura Donnelly Telegraph 23 July 2017
http://www.telegraph.co.uk/news/2017/07/23/exclusive-national-review-schemes-divert-patients-ae-amid-safety/

management, with an English national average of just 19% ambulance trust staff reporting good communication with senior managers in 2016.

Key 2016 staff survey results on English ambulance trusts:

Ambulance Service	Staff-staff bullying in the previous 12 months	Staff reporting good communication with senior management	Overall CQC rating
East Midlands	28%	17%	Requires improvement
East of England	29%	19%	Requires improvement
London	32%	22%	Requires improvement
North East	25%	18%	Good
North West	28%	20%	Requires improvement
South Central	23%	22%	Good
South East Coast	40%	12%	Inadequate
South Western	21%	28%	Requires improvement
West Midlands	33%	19%	Outstanding
Yorkshire	29%	15%	Good

Source: National NHS staff survey

NB. The National NHS staff survey results stated that the best staff-staff bullying score for an ambulance trust in 2016 was 14%, but I found no trust with such a score. I have asked the provider organisation which operates the staff survey about this.

Staff survey data for the Welsh Ambulance service in 2016 revealed that 21% of staff reported bullying by other staff and 21% of staff reporting that communication with senior managers was effective.

http://www.ambulance.wales.nhs.uk/assets/documents/5da36e00-1e47-4285-854c-0fa55e788f50636175031416660627.pdf

Whistleblowing by ambulance staff to the media has now become a regular occurrence. [33]

[33] Press reports of whistleblowing about ambulances and related services:

http://www.edp24.co.uk/news/health/second-whistleblower-says-under-fire-ambulance-trust-is-also-using-volunteer-community-first-responders-to-hit-targets-1-5107179

http://www.edp24.co.uk/news/health/second-whistleblower-says-under-fire-ambulance-trust-is-also-using-volunteer-community-first-responders-to-hit-targets-1-5107179

Curiously though, there are no published CQC 'intelligent monitoring' reports at all on ambulance trusts. It was therefore not possible to check the extent to which CQC has received whistleblowing alerts about ambulance services. [33]

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https://www.hsj.co.uk/east-of-england-ambulance-service-nhs-trust/exclusive-whistleblower-warns-trust-is-worst-its-ever-been-as-staff-shortage-revealed/7020389.article#.WZgIBxoBC3Q.twitter

http://www.telegraph.co.uk/news/2017/02/13/bullying-desperate-999-call-handlers-led-suicide-attempts-scandal/

http://www.bristolpost.co.uk/news/bristol-news/whistleblower-nhs-bristol-ambulance-paramedics-163044

http://www.bbc.co.uk/news/uk-england-38694213

http://www.yorkpress.co.uk/newS/11682028.Row_after_launch_of_ambulance_service_whistleblower_website/?commentSort=score

http://www.mirror.co.uk/news/uk-news/ambulance-service-crisis-warns-paramedic-6961702

http://www.plymouthherald.co.uk/probe-launched-whistleblower-s-claims-health/story-29308468-detail/story.html

http://www.bbc.co.uk/news/health-38535946

https://www.hsj.co.uk/hsj-local/providers/south-western-ambulance-service-nhs-foundation-trust/exclusive-regulator-to-probe-whistleblower-ambulance-trust/7004930.article

http://archive.camdennewjournal.com/news/2011/oct/whistleblower-says-ae-ambulance-crews-go-out-without-paramedics

https://planetradio.co.uk/mfr/local/news/watch-safety-watchdog-looking-north-ambulances/

https://www.spectator.co.uk/2014/08/londons-999-emergency/

[33] CQC 'intelligent monitoring' reports are of limited use in providing information on whistleblowing events as they only say whether there have been alerts received during a given reporting period, without indicating how many reports have been received.

The Rule 43 and Section 28 data shows that there has been an increase in coroner's warnings about ambulance services, and in particular the number of warnings about ambulance delays.

Under the old Rule 43 arrangements there were a total of 48 coroners' warning reports about ambulance trusts between July 2008 and March 2013:

Reporting period	**Number of Rule 43 reports issued About NHS ambulance trusts**
17 July 2008 – 31 March 2009 (eight months)	3
1 April 2009 – 30 September 2009	4
1 October 2009 – 31 March 2010	4
1 April 2010 – 30 September 2010	7
1 October 2010 – 31 March 2011	7
1 April 2011 – 30 September 2011	7
1 October 2011 – 31 March 2012	4
1 April 2012 – 30 September 2012	5
1 October 2012 – 31 March 2013	7
TOTAL for period 17 July 2008 to 30 September 2013 (62 months)	**48**

Source: Chief Coroner's bi-annual summaries of reports and responses under Rule 43 of Coroners Rules

These are the relevant case reference details, summarised issues of concerns and ambulance services involved:

https://minhalexander.files.wordpress.com/2016/09/rule-43-reports-on-nhs-ambulance-services-pub1.xlsx

During the period July 2008 to March 2013, there were three Rule 43 reports that explicitly related to ambulance response times or ambulance service capacity (London Ambulance Service, Welsh Ambulance Service and South Central Ambulance Service)

Since then, there seems to have been an increase in coroners' concerns as I found a total of 84 coroners' Section 28 reports on ambulance services, and two Section 28 reports on related call handling, that have been published up to 31 July 2017.

FINANCIAL YEAR	**NUMBER OF PUBLISHED CORONERS' SECTION 28 REPORTS RELATING TO AMBULANCE SERVICES AND RELATED CALL HANDLING**
2013/14 (30 July 30 to 31 March 2014)	12
2014/15	19
2015/16	22
2016/17	27
2017/18 up to 31 July 2017	6
TOTAL	**86**

Almost all the Section 28 reports on ambulance services related to NHS services, but three private ambulance services featured.

The London, North West, East Midlands, West Midlands and Welsh Ambulance Services accounted for the most published coroners' warnings in the NHS:

NHS ambulance trust	**Number of coroners' Section 28 reports published up to 31 July 2017**
London Ambulance Service	18
North West Ambulance Service	13
East Midlands Ambulance Service	9
West Midlands Ambulance Service	7
Welsh Ambulance Service	7
East of England Ambulance Service	6
North East Ambulance Service	4
South Western Ambulance Service	6
Yorkshire Ambulance Service	6
South East Coast Ambulance Service	3
South Central Ambulance Service	3

Importantly, 48 of the 86 (55.8 %) published Section 28 reports on all ambulance services noted delays in ambulance response and diversion to less acute services which had either contributed to deaths or could contribute to deaths in future.

There appeared to be an increasing trend in reports about delays, especially compared to the relatively low number of warnings about delays under the old Rule 43 arrangements.

FINANCIAL YEAR	NUMBER OF PUBLISHED CORONERS' SECTION 28 REPORTS RELATING TO AMBULANCE SERVICE DELAY & RELATED ISSUES OF CALL HANDLING AND DIVERSION TO LESS ACUTE SERVICES
2013/14 (30 July 30 to 31 March 2014)	6
2014/15	8
2015/16	13
2016/17	16
2017/18 up to 31 July 2017	5
TOTAL	**48**

Even allowing for the fact that Section 28 and Rule 43 reports are not wholly comparable, the increase from three Rule 43 reports on ambulance delays to 47 Section 28 reports on ambulance delays suggests that there is a real problem.

Eight of the published Section 28 reports featuring cases of ambulance delay had been sent to the Department of Health. [35]

This is the supporting data on all the ambulance and related Section 28 reports from the last four years:

https://minhalexander.files.wordpress.com/2016/09/section-28-reports-on-ambulance-services-published-up-to-31-july-2017-pub.xlsx

Apart from the South Central Ambulance Service, all NHS ambulance trusts received one or more Section 28 reports relating to delayed ambulance response

[35] The eight ambulance Section 28 reports that were sent to the Department of Health:

Yusuf Abdismad: https://www.judiciary.gov.uk/publications/yusuf-abdismad/
Liam Coleman https://www.judiciary.gov.uk/publications/liam-coleman/
Robert Hogg https://www.judiciary.gov.uk/publications/robert-hogg/
Paul Murray https://www.judiciary.gov.uk/publications/paul-murray/
Barbara Patterson https://www.judiciary.gov.uk/publications/barbara-patterson/
Keith Ruston https://www.judiciary.gov.uk/publications/keith-ruston/
Peter Scott https://www.judiciary.gov.uk/publications/peter-scott/
James Sutton https://www.judiciary.gov.uk/publications/james-sutton/

Moreover, some of the coroners' remarks indicated that there had been previous incidents of delay and related systemic issues.

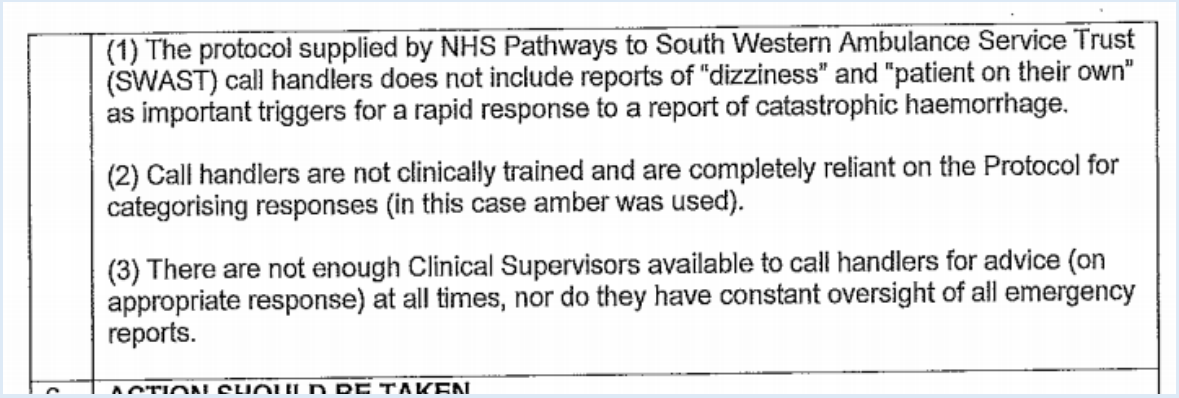
Coroners pointed out that ambulance delays were due to capacity and closely related to other severe pressures in the system, which cause delays in hospital handover and ambulance queuing at A&E departments.

Compounding problems of service capacity and handover delays at A&E, there were also issues about the effectiveness and safety of call handling and diversion services.

In some deaths, referrals to ambulance services had been assigned lower priority than was appropriate. A question arises of whether this is partly a consequence of a system that is so overwhelmed that it is understandably and foreseeably becoming de-sensitised to risk.

Some examples follow.

After a death in which it took one and half hours for an ambulance to attend, the coroner for Exeter and Greater Devon noted on 21 June 2017:



(1) The protocol supplied by NHS Pathways to South Western Ambulance Service Trust (SWAST) call handlers does not include reports of "dizziness" and "patient on their own" as important triggers for a rapid response to a report of catastrophic haemorrhage.

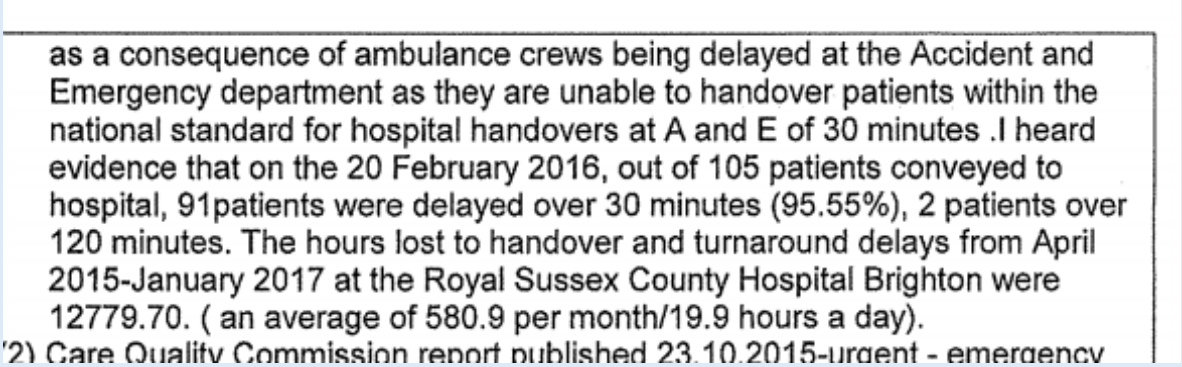
(2) Call handlers are not clinically trained and are completely reliant on the Protocol for categorising responses (in this case amber was used).

(3) There are not enough Clinical Supervisors available to call handlers for advice (on appropriate response) at all times, nor do they have constant oversight of all emergency reports.

ACTION SHOULD BE TAKEN

https://www.judiciary.gov.uk/publications/colin-james/

The Brighton & Hove coroner noted on 5 April 2017:



as a consequence of ambulance crews being delayed at the Accident and Emergency department as they are unable to handover patients within the national standard for hospital handovers at A and E of 30 minutes .I heard evidence that on the 20 February 2016, out of 105 patients conveyed to hospital, 91patients were delayed over 30 minutes (95.55%), 2 patients over 120 minutes. The hours lost to handover and turnaround delays from April 2015-January 2017 at the Royal Sussex County Hospital Brighton were 12779.70. (an average of 580.9 per month/19.9 hours a day).

(2) Care Quality Commission report published 23.10.2015-urgent - emergency

https://www.judiciary.gov.uk/publications/ronald-bennett/

On the 21 June 2017 the Exeter and Greater Devon coroner noted:

(1) The protocol supplied by NHS Pathways to South Western Ambulance Service Trust (SWAST) call handlers does not include reports of "dizziness" and "patient on their own" as important triggers for a rapid response to a report of catastrophic haemorrhage.

(2) Call handlers are not clinically trained and are completely reliant on the Protocol for categorising responses (in this case amber was used).

(3) There are not enough Clinical Supervisors available to call handlers for advice (on appropriate response) at all times, nor do they have constant oversight of all emergency reports.

https://www.judiciary.gov.uk/publications/colin-james/

After the death of a patient who had been waiting in an ambulance queue for 7 hours, the coroner for North Wales (East and Central) noted on 14 March 2017:

3. It is of grave concern to me that my statutory duty requires me to report these concerns by way of regulation 28 reports on a very regular basis and that despite previous such reports there continue to be substantial delays in the handover of patients particularly as a result of problems in patient flow resulting in an inability to admit patients who require treatment.

https://www.judiciary.gov.uk/publications/rebecca-evans/

After a neonatal death, the Nottinghamshire coroner noted on 11 May 2016:

5. It is clear that resources played a part in these tragic events. No DCA was available to attend this emergency until 30 minutes after the call, and it took a further 12 minutes for a DCA to arrive after that. The time between the 999 call and [redacted] being handed over to maternity staff was an hour and 15 minutes. It was clear from the outset that [redacted] would require urgent transfer to hospital – a mere 4 miles from her home address – but no resource was available. The evidence of those 'on the ground' clearly showed that this is far from an isolated incident, and I remain concerned that there is a risk of future deaths if this is not addressed.

https://www.judiciary.gov.uk/publications/mia-gibson/

On 17 November 2016 the coroner for Hertfordshire noted:

5	**CORONER'S CONCERNS** I heard evidence that this was not an unusual amount of outstanding calls or an unusual level of waiting time. This was the position on the 26th January 2016 and I heard evidence that this is still the position now. 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 **MATTER OF CONCERN** is as follows. – (1) Consistently high levels of outstanding emergency calls and waiting times that far exceed the service's own target response times are likely to put lives at risk.

https://www.judiciary.gov.uk/publications/brian-mills/

On 25 May 2016 the coroner for Nottinghamshire noted:

The **MATTERS OF CONCERN** are as follows :

I remain very concerned about resource issues for this ambulance service. I raised similar concerns in a Prevention of Future Deaths Report in the case of MG, dated 11 May 2016.

We heard evidence from a senior manager at EMAS during the inquest. I asked the service to advise me to what extent they had had to invoke Capacity Management Plans in the last 12 months. I was advised that EMAS has had to invoke such a Plan (to at least level 3) for 9 out of the last 12 months.

The issue in this case and that of MG was essentially a matter of resource. In essence, I found that there is only so much an ambulance service can do where they simply do not have an ambulance to send. Demand is clearly greater than the resources they have most of the time, given that a CMP has been in place for 75% of the last 12 month period.

I am very concerned that this poses a serious risk to the public served by this ambulance service. We heard also that recruitment is an ongoing problem – which may be exacerbated by the huge demand placed on its employees by this resource issue.

Finally, I was made aware that one of the key problems in ensuring ambulance availability is delayed handover of patients at hospitals. I believe the trust is already working to improve this, and I include EMAS in this report in this respect only. Other recipients of the report are required to respond with regard to matters of resourcing only.

1. I consider that there is a risk of future deaths as set out above unless an urgent review of resources is undertaken.
2. Consideration should be given to strategies to improve handover times at hospitals.

https://www.judiciary.gov.uk/publications/peter-scott/

The South Wales Central coroner noted on 20 April 2016:

The **MATTERS OF CONCERN** are as follows. –

1) As against an internal Welsh Ambulances Services Trust response target time for an Amber 2 call of 20 minutes, an ambulance did not arrive at the scene for nearly 2 hours and 40 minutes. It was accepted in evidence on behalf of the Welsh Ambulance Services Trust that this response time was unacceptable and that the situation *could happen again.*

https://www.judiciary.gov.uk/publications/ronald-hamer/

After the death of a 28 year old woman from haemorrhage due to ruptured ectopic pregnancy, the coroner for Inner London North noted:

The **MATTERS OF CONCERN** are as follows. –

(1) Ambulance response times were the focus of evidence provided at the inquest. The most recent available response times show a worsening picture and submissions to date from LAS set out only a proposed 'investment business case' as to how resources can be freed-up. I have not been provided with the

2

details of this proposal. I am not satisfied that sufficient steps have been taken to demonstrate that the risk of future deaths, from increasing response times, has been addressed.

(2) A related issue about which I am also concerned is that LAS set out that there are 400 vacant positions, without further detail as to what steps are being taken to address this shortfall;

(3) Several training issues were prominent at the inquest and evidence has been

https://www.judiciary.gov.uk/publications/sabrina-stevenson/

On 23 March 2016 the coroner for Teeside noted:

4	**CIRCUMSTANCES OF THE DEATH** Mr Singh had consumed high levels of alcohol during the day on 2 November 2015. At approximately 11.45pm his wife went to bed leaving him watching television downstairs. At approximately midnight she went to check on him and found him lying on the floor. He was breathing but unconscious. She rang the ambulance services. Despite assessing the call as a R1, with a target response time of 8 minutes it took 27 minutes for the ambulance to arrive. Mr Singh died whilst in the ambulance.
5	**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. – A root cause analysis comprehensive and independent investigation report undertaken by the North East Ambulance Service discloses that the reasons for the delay of the ambulance arrival include severe demand and shortages in the division. Road closures and diversions did not assist the crews.
6	**ACTION SHOULD BE TAKEN**

https://www.judiciary.gov.uk/publications/mandeep-singh/

On 12 October 2015 the Northamptonshire coroner noted:

The finding at inquest was that on 30th January 2015 at 22.10 hours, the deceased had a fall at her home. An ambulance conveyed her to Kettering General Hospital where death was confirmed at 02.26 hours on 31st January 2015.

A narrative conclusion was delivered in the following term

"Mrs Withers' death was accidental however her death was contributed to by neglect. The 2 hour 50 minute delay between the 999 call being placed and the paramedic arriving probably did on the balance of probabilities contribute to Mrs Withers' death"

https://www.judiciary.gov.uk/publications/mrs-withers/

On 22 September 2015 the coroner for Central Lincolnshire noted:

5.	**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. – (I) Significant and unacceptable delays occurred in despatching an ambulance to a patient who was unconscious and had clearly suffered a serious head Injury. Such delay is potentially highly prejudicial to those who rely upon the services provided by EMAS.

https://www.judiciary.gov.uk/publications/stuart-knight/

On 21 May 2015 the coroner for North Northumberland noted:

computerised system piloted in the North East and since rolled out for use by 6 other Healthcare Trusts nationally, has a fault in that it does not advise non clinical call handlers to issue CPR advice unless a patient has stopped breathing. This fails to recognise the need for CPR in cases of Aganol (heavy/noisy breathing which is insufficient to sustain life). This fault was pointed out to Pathways by the Clinical Section Manager for North East Ambulance Service NHS Foundation Trust.prior to the latest update being installed in early 2014 (Update 9). Pathways refused to amend the system. That fault remains in place to date.

3. The failure by the ambulance dispatcher to dispatch an ambulance closer to the deceased's location
4. The target time for the arrival of the ambulance was 8 minutes, this was breached. The ambulance did not arrive for 15 minutes.
5. During the inquest evidence was given that there is a national shortage of paramedics, which is particularly acute in the North East.
6. During the inquest evidence was given that ambulance availability is being jeopardised by crews being delayed at hospital when handing patients over to Accident and Emergency staff.

ACTION SHOULD BE TAKEN

https://www.judiciary.gov.uk/publications/barbara-patterson/

On 13 May 2015 the North London coroner noted:

	Thirdly that had Mr Murray been taken to hospital following the call at 12.19 arriving there before his cardiac arrest it is likely that he would not have died when he did. Mr Murray did receive an emergency response by a first responder after a 4th call saying that Mr Murray had become unresponsive, a criteria that generates an emergency response. Mr Murray was taken to hospital arriving at 14:50 pm where despite treatment he died.
5	**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. – That there were insufficient resources available for the London Ambulance service to meet the demand on the 8th February 2013 at 12.19

https://www.judiciary.gov.uk/publications/paul-murray/

On 6 August 2015 the Buckinghamshire coroner noted:

The **MATTERS OF CONCERN** are as follows. –

(1) An Investigation Report (2014/13029) prepared by [redacted] for South Central Ambulance Service (incident no: IR 4865) revealed three areas of concern.
(2) The third area of concern stated specifically "NHS Pathways toddler/child Pathways are not necessarily highlighting/picking up very sick children. This is not the first event relating to incidents involving toddlers/children and this has been highlighted through our own Pathways Lead to NHS Pathways for investigation"
(3) The evidence given by [redacted] during the Inquest was that no changes have been made to the toddler/child pathways, and that the third area of concern identified in the

https://www.judiciary.gov.uk/publications/robert-hogg/

After the death of a 15 year old girl the coroner for Inner London West noted on 19 December 2014:

4	**CIRCUMSTANCES OF THE DEATH** It was clear from the evidence taken during the inquest that she suffered an acute rupture of one of the cusps of her aortic valve causing her to go into crashing heart failure. Her brother attempting to seek urgent medical advice on her behalf and made calls to 999 and 111. For various reasons she was not recognised by the call takers to be as unwell as she was until the final call to 999 such that the provision of emergency LAS services were delayed. This delay was not causative in her death on the balance of probabilities, but various incidents occurred, such as the downgrading of the call by a call taker and a failure to re-triage when the brother called back by a call taker.
5	**CORONER'S CONCERNS**

https://www.judiciary.gov.uk/publications/samia-shara/

On 12 September 2014 the coroner for East and Central North Wales noted:

At around 16.00 hours on the 25th March 2014 a call was made from the home of Clive Harold Turner to the Welsh Ambulance Service NHS Trust requiring medical assistance for him.

Due to the lack of available resources a First Responder did not attend until 1 hour and 27 minutes after the initial call. The First Responder assessed Mr Turner as requiring admission to hospital and requested assistance. No ambulances became available to provide this assistance until 21.30 hours, this being 5 hours 30 minutes after the initial 999 call and more than an hour after the First Responder had advised control that Mr Turner was at the limit with the amount of morphine given.

The ambulance arrived at the Maelor Hospital Wrexham at 21.53 hours, however there was a further 2 hour delay in his handover to nursing staff at 23.44, 8 hours and 45 minutes after the original 999 call.

https://www.judiciary.gov.uk/publications/clive-turner/

On 9 January 2014 the Bedfordshire and Luton coroner noted:

CIRCUMSTANCES OF THE DEATH

Albert Hand suffered a fall at around 13.00 hours on 1st November 2013 at the Arndale Shopping Centre in Luton. A call was made to the Ambulance Service via 999 and a Paramedic attended at 13.32 hours who conducted an assessment and recorded a Glasgow Coma Scale (GCS) of 11. The Paramedic then requested a "Hot 2" transfer to hospital. The "Hot 2" ambulance arrived at 14.15 hours and left the scene at 14.37 hours, arriving at the Luton & Dunstable Hospital at 14.51 hours, almost an hour and a half following the original call. His GCS had then fallen to 7. The Clinical Manager for the Ambulance Service explained in his evidence that a patient could be waiting for up to three hours and ".....the waits are getting longer". Priority is given to diverting an ambulance to an incident where the person has suffered a respiratory or cardiac arrest, even in situations where the patient has suffered a head injury

https://www.judiciary.gov.uk/publications/albert-james-hand/

On 30 October 2013 the coroner for Powys, Bridgend and Glamorgan Valleys noted:

The **MATTERS OF CONCERN** are as follows. –

(1) Mr Johns son clearly confirmed the low blood sugar at the beginning of the call. This critical important information was not factored into the advice provided to him by the operator.
(2) The computer programme used by the ambulance service does not take into account critical clinical information as a result the operator incorrectly advised CPR despite the risks that entails.

https://www.judiciary.gov.uk/publications/johns-2013-0279/

Also of concern, there were no published responses to 50 of the Section 28 reports on ambulance services and kindred.

Specifically, there were no published responses to 26 of the 48 Section reports about ambulance delays.

Of thirteen Section 28 reports about ambulance services, addressed to the Department of Health for action to prevent future deaths, there was no published response in eleven cases.

Of the published responses by the government and central bodies about ambulance deaths, there were repeated promises to review and mentions of work in progress, including an NHS England review led by Bruce Keogh NHS England Medical Director.

However, the continuing stream of coroner's warnings suggests that serious risk to the public is not being ameliorated quickly enough.

CONCLUSION

The published Section 28 report data for England and Wales, its completeness and presentation raise issues of government transparency, learning from deaths and whether the government is doing enough to protect the public.

The incomplete data on responses to Coroners' warnings and the apparent lack of a clear process for dealing with unsatisfactory responses raise questions about the purpose and effectiveness of the Section 28 reporting system.

The audit cycle needs to be more clearly and proactively closed, with proper accountability to the public.

Failure to take action in response to avoidable deaths or unacceptable risks to the public should not be exposed by the next similar death, as seems to be implied by some of the Section 28 reports, but by active tracking by the State.

The hundreds of coroners' warnings about the NHS and notwithstanding the caveats about the data, an apparent escalation in warnings about NHS emergency services emphasise the need to for the government to demonstrate that it is taking effective action.

The data on repeated coroners' warnings about ambulance deaths and serious risk to public safety calls into question the validity of CQC's regulatory performance and findings. In particular, CQC's recent rating of West Midlands Ambulance Service as 'Outstanding' [36] is hard to reconcile with the reality on the ground.

[36] http://www.cqc.org.uk/provider/RYA

CQC has previously been criticised on a number of occasions for not acting upon intelligence from coroners. After one such occasion CQC issued a typical press release in September 2015 promising to learn lessons – see appendix below, but questions arise about whether the lessons have been effectively learned.

I have written to the Chief Coroner to seek clarification about a number of matters including how many Section 28 reports and responses have been published, the processes governing publication and non response to Section 28 reports. I have also asked that the Section 28 data on his website is made more accessible to the public.

The Department of Health and other central NHS bodies will also be asked to explain more about their handling of Section 28 reports.

Dr Minh Alexander 24 August 2017

APPENDIX - PRESS CRITICISM OF CQC FAILURE TO ACT UPON CORONERS' WARNINGS AND CQC RESPONSE SEPTEMBER 2015

Elderly people put at risk as watchdog fails to act on warnings of 'fatally negligent' care homes, Melanie Newman and Oliver Wright, Independent, 2 September 2015:

http://www.independent.co.uk/life-style/health-and-families/health-news/elderly-people-put-at-risk-as-watchdog-fails-to-act-on-warnings-of-fatally-negligent-care-homes-10483573.html

CQC response to story in The Independent

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A story has been published in The Independent *today (Thursday 3 September) focussing on CQC's response to Regulation 28 reports, which are issued by the Coroner and aimed at preventing future deaths.*

The story focusses on a number cases (between 2013 and 2015) where someone died - either in a care home or following care or treatment at home - where the Coroner concluded that further action needed to be taken to prevent a future death in similar circumstances from occurring.

Our Chief Executive, David Behan, gave an interview to The Independent *to explain how CQC has improved the processes we have to in place to ensure that we respond to and learn from the issues highlighted by these Regulation 28 reports.*

***CQC's Chief Executive, David Behan, said:**.*

"When someone dies while being cared for in a health or social care setting and the Coroner concludes that action is needed to prevent future deaths from occurring, a Regulation 28 report is issued. In most cases, the provider will be the named respondent, meaning that they have responsibility for preventing a future death in similar circumstances.

"In some cases, however, CQC is the named respondent, meaning that the Coroner has concluded that the regulator also has a role to play in ensuring that people are protected in the future.

"In those cases where CQC is identified as the named respondent, it is absolutely right that we should expect CQC to use this information to inform our regulatory activities. This includes how we respond to levels of risk as well as ensuring providers act on the recommendations of Coroner's Reports.

"Last year, I initiated a review of our processes and procedures, as I had recognised that we were not always receiving these Reports. In some cases where we did, it was also clear we were not always dealing with these effectively enough.

> *"We have made a number of changes to strengthen and tighten our ways of working, including:*
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> - *Establishing a single point of contact for Coroners' reports to ensure any concerns raised are effectively logged, analysed, managed and reviewed.*
> - *Better and earlier engagement with Coroners around the time of a person's death.*
> - *A proposed and drafted Memorandum of Understanding with the Coroners' Society to strengthen our working relationships and ensure we receive all Coroners' reports in health and social care inquests in order to help reduce risk more effectively and promptly.*

"We've made progress, but I'm far from being complacent. We know there is more work to do. Improvement is a continual commitment and we are making sure we are properly embedding our new process, further developing our relationship with the Coroners' Society and being really clear about what we expect our staff to do when they receive these types of reports.

"But this isn't just about processes – it's about people's lives. For that reason, we need to keep working hard to ensure that we get it right every time."

Last updated:

29 May 2017

https://www.cqc.org.uk/news/stories/cqc-response-story-independent