

Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA Telephone:03000 616161 information.access@cqc.org.uk www.cqc.org.uk

Mr R J Balmain HM Senior Coroner Black Country Smethwick Council House High Street Smethwick West Midlands B66 3NT

23 February 2015

Dear Mr Balmain

Re: Inquest into the death of James Dwayne Clarke

I apologise for the delay in responding to your letter dated 10 September 2014, but as you are aware in order to inform a fully considered response to your report we have sought additional details about the inquest given that we were an interested person in the proceedings.

We were very sad to read about the death of Mr Clarke and the circumstances in which he died. Thank you for your report and the requirement for us to review what actions should be taken to try to prevent the occurrence or continuation of such circumstances in the future.

Please treat this letter as the formal response of the Care Quality Commission (CQC) to your report dated 10 September 2014.

In your report and pursuant to the requirements of Regulation 28 of the Regulations, you require the CQC to provide details of any action that has been taken or which is proposed to be taken in response to the concerns highlighted in your report, or an explanation as to why no action is proposed if appropriate.

In terms of background and context, the provision of care to Mr Clarke at the time of his death was provided through an organisation Complete Care Services, trading as CCS Central Limited, West Midlands House, Gypsy Lane, Willenhall, Wolverhampton, West Midlands WV13 2HA. This organisation was registered with the CQC under the Health and Social Care Act 2008 in October 2010. The organisation was registered to provide the regulated activity "personal care" from a location in Gypsy Lane, Willenhall. In April 2012 the organisation voluntarily de-registered the location in Gypsy Lane, Willenhall and applied to register to provide the same regulated activity from a location in Stafford Street, Willenhall.

We have had a number of changes in structures and personnel since the time of Mr Clarke's death, so I am somewhat reliant on information from our computer record systems to provide the following information.

We were notified of the death of Mr Clarke by the local authority on 11 April 2011. This was logged on our system as information of concern. The record was closed on 21 April 2011 without any record of activity taken by CQC, the local authority or the police. The inspector who held this provider on their portfolio recalls that they were aware that a safeguarding investigation was to proceed. We hold no further records of that or its outcome.

In terms of actions that we have undertaken, in May 2011 we carried out a responsive inspection unannounced. This was the service's first inspection under the Health and Social Care Act 2008. This would have focused on the issues considered relevant at the point of inspection and any information of concern that we held. We inspected against four of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These were:

- Regulation 9 which relates to how the provider protects the care and welfare of people using the service
- Regulation 10 which relates to how the provider assesses and monitors the quality
 of their service provision
- Regulation 11 which relates to the arrangements that the provider has in place to safeguard people from abuse (which includes neglect and acts of omission)
- Regulation 17 which relates to the arrangements the provider has to deal with complaints

At that inspection it was our judgement that the provider was compliant with Regulation 11, and had appropriate arrangements in place to protect people from abuse. However, it was found that risk assessments were not up to date so the provider was required to improve these.

Since that time, we have inspected the organisation's location at Stafford Street and found it to be compliant with all regulations inspected. There have been no concerns sufficient to trigger further responsive inspections or regulatory action.

As your office has confirmed, CQC were not informed about the inquest proceedings and we were not invited to contribute or respond at that time.

Our inspection in May 2011 found that there were shortfalls in the provider's approach to assessing and mitigating risk to people using services. Our inspections since then

(although to a different location and therefore different legal entity) have not found any shortfalls. I hope that you find this of some reassurance.

In April 2015 CQC will adopt the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, known as the "fundamental standards". The changes in the regulations have emerged from the Robert Francis recommendations that there should be very obvious standards below which care must not fall. Regulation 9 will ensure that people receive care and treatment that is personalised for them and meets their needs; Regulation 12 is intended to prevent people from receiving unsafe care and treatment, and prevent avoidable harm or risk of harm. These regulations in particular will require providers to ensure that care is planned and delivered in a way that makes it crystal clear to care staff what is required of them, and that staff are experienced, trained and competent in the areas where they are providing that care.

In implementing the new fundamental standards, our inspection processes have been developed. We will conduct longer, more in-depth inspections with a team approach designed to "get under the skin" of care services. We have key lines of enquiry which are explored and reported on consistently. Each care service will be rated either Outstanding, Good, Requires Improvement or Inadequate. We will continue to use our enforcement powers where services do not deliver safe services.

We will ensure that your report is noted and informs the next ratings inspection that takes place of Complete Care Services; although the information is now a little dated the issues are well worth a further examination of their processes and training provision.

Please do not hesitate to contact me if you require any further information. I am the Head of Inspection for the Black Country and would be happy to hear from you about this or any other situation of concern, and would welcome a meeting if you would like to hear more about CQC and our current activity in your area.

With best wishes

Yours sincerely



Head of Inspection Central (West) Adult Social Care