HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

Mrs Jean Harkin
Assistant Coroner
Office of HM Coroner
County of Cheshire
West Annexe
Town Hall
Sankey Street
Warrington
Cheshire
WA1 1UH

Email to: [redacted]

16 October 2017

Our Reference: MRR1-4155695452

Dear HM Coroner

Ref: Maureen Ann Colclough

Re: Regulation 28 Report - Inquest into the death of Maureen Ann Colclough

Thank you for sending the Care Quality Commission (CQC) a copy of the Regulation 28 Report issued following the inquest touching on the death of Maureen Ann Colclough. We are writing to you with our response to the matters of concern raised in relation to Unique Care Services.

We note the legal requirement upon CQC to respond to your report within 56 days and thank you for granting CQC a four week extension to provide a response.

Following the receipt of the Regulation 28 Report we held three internal management review meetings to discuss the findings of the report and determine what action CQC should take. We reviewed our records and found that the Registered Provider had not notified us of the death of Maureen Ann Colclough as legally required. This failure to report has been raised with the Registered Provider and we will consider whether criminal enforcement action is appropriate.

We also agreed to conduct an inspection of the service, reviewing staff training in the event of an emergency and also the oversight that is provided by [redacted]. Two inspectors visited the service on 11 September 2017 and 21 September. I have detailed some of our findings under your specific questions below.

Background

The Registered Provider, [redacted] was registered on 1 December 2014. In May 2017, the Registered Provider moved location from Unique Care Services, 19 Caldy Drive, Great Sutton, Ellesmere Port, Cheshire, CH66 4RN to Stanlaw Business Centre, Unit C11 Stanlaw Abbey Business Centre, Dover Drive, Ellesmere Port, Merseyside, CH65 9BF.

Unique Care Services was inspected on 17 and 24 October 2016. The service was rated 'inadequate' in the Well Led domain, 'requires improvement' in the Safe domain and 'good' in the Responsive, Effective and Caring domains. The service was rated 'requires improvement' overall. We issued a requirement notice for a breach of regulation 17 (good governance).

We inspected the service again in May 2017. The service was rated 'good' overall with 'good' ratings in four domains (Safe, Effective, Caring and Responsive) and 'requires improvement' in the Well Led domain.

Coroner's concerns

In relation to the specific matters of concern raised in your report:

1 Inadequate training of staff to recognise emergency situations.

During our recent inspection we found that all members of staff had received basic life support training. This took place during August and early September 2017. The Registered Provider confirmed that additional classroom based training has been provided to staff on 26 September and 3 October 2017.

We also noted that the two members of staff involved in the incident had received training prior to the incident and one of them has subsequently received updated training on emergency procedures. CQC is of the view that although the Registered Provider has provided adequate training for staff in dealing with emergency situations in response to the death of MC, the lack of training for some staff prior to December 2016 and the delay in the provision of that training put service users at risk at that time. Although the risk has been mitigated whereby all staff have now had training, CQC considers that there had been a system failure to oversee the management of the service.

2 Relying on presumptions when finding an unresponsive patient in a serious situation.

CQC is of the view that carers relying on presumptions when finding an unresponsive patient in a serious condition place that individual at high risk. Whilst some of this risk has been mitigated as emergency training has been provided for staff, more robust action by the Registered Provider is required with regard to his oversight of the service.

Due to the concerns found during our inspection CQC is now taking substantive enforcement action. In addition, the Registered Provider is required to provide CQC with an action plan detailing how they intend to improve the care provided to service users. Inspectors will continue to monitor the service to ensure that service users receive safe and effective care.

A copy of the report detailing our findings will be available when published on our website.

Should you require any further information please do not hesitate to contact me on my telephone number [redacted]

Yours sincerely

[redacted]

[redacted]
Head of Inspection