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Ms Anna Morris
Assistant Coroner South Manchester
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3GA

14/08/2017

RE: Regulation 28 Report – Mr Michael Bingham

Dear Ms Morris

I can confirm, as you indicated in your report, that the work to the internal doors at Hilltop Court have been completed, and that either screech alarms or key box panels have been installed. These mechanisms are also linked to the internal nurse emergency call system so the staff will be alerted should one of the internal doors be opened via the emergency release mechanism.

I can confirm that the work to fit screech alarms to all internal emergency exit doors has been completed in all of Harbour Healthcare's other care homes with the exception of Bentley Manor Nursing Home in Crewe, which will be completed by August 31st 2017.

I can also confirm that risk assessments have been completed on all modifications and that new internal procedures have been implemented to ensure the staff teams are familiar with the new systems and that regular drills are conducted and recorded to better enable staff to respond appropriately when a screech alarm sounds.

Thank you for your guidance on this matter.

Yours sincerely

Andrew Worsley
CEO

CareQuality Commission

CQC
Citygate
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Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
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www.cqc.org.uk

Date: 20/10/2017
Reference number: 5423/HC

Dear HM Coroner,

Care Quality Commission ('Commission')
Health and Social Care Act 2008

Re: Regulation 28 report in relation to the death of Mr. Michael Bingham

I am writing in response to the Regulation 28 report which you issued on 31 July 2017 following the inquest into the sad death of Mr. Michael Bingham. .

The registered provider for Stepping Hill Hospital is Stockport NHS Foundation Trust.- At the time of Mr. Bingham's death the trust had active Requirement Notices that had been issued in August 2016 against:

- Regulation 10 (dignity and respect);
- Regulation 12 (safe care and treatment);
- Regulation 14 (meeting nutritional and hydration needs);
- Regulation 17 (good governance); and
- Regulation 18 (staffing)

of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (all further references to Regulations in this letter are to these 2014 Regulations unless specifically stated otherwise).

(A Requirement Notice formally notifies a provider that we consider they are in breach of legal requirements and should take steps to improve standards.)

We undertook an unannounced inspection of Stepping Hill Hospital on 21 and 22 March 2017. A copy of the report can be found on our website at: www.cqc.org.uk/sites/default/files/new_reports/AAAG7959.pdf. This inspection was conducted in response to concerns received by the Commission and analysis of intelligence available to us. This inspection focused on the urgent care service (Emergency Department) and the medical services (medical care wards).

As part of this inspection we requested documentation pertaining to all serious incidents which had been reported in the Emergency Department for the 12 months

prior to our inspection. This information was received in April 2017. When we received this information we then requested the investigation reports for a number of the incidents to review in closer detail.

One of these records related to Mr. Bingham. The review of these records took place between April and May 2017. At the time of our inspection and review the investigation report was not finalized and we were made aware by the trust that the case was awaiting an inquest.

The case was specifically discussed by the inspectors undertaking the inspection with the inspection manager leading the inspection team and the action plan in relation to this incident was reviewed. This action plan was a standard action plan contained at the end of a serious incident review. The action plan contained key actions to reduce the risk of re-occurrences which the trust had identified through their review of the incident. The trust advised that the action plan was to be reviewed on a regular basis. The case was then raised as part of our internal management review process for the inspection, within which we held several meetings to determine what action should be taken in response to this incident and also the wider issues identified as part of the inspection.

At that time it was decided that we would wait for the outcome of the inquest and then hold another management review meeting specifically looking at Mr. Bingham's case. This was in relation to both our civil and criminal prosecution powers.

In addition to this and to secure immediate improvement and safety we also decided to take action in response to the concerns we identified during the inspection including issues relating to Mr. Bingham's case. This action is summarized below:

- A risk summit was convened with key stakeholders including NHS England, NHS Improvement, Clinical Commissioning Groups, General Medical Council. Stockport Local Authority and the North West Medical Deanery. This meeting was held on 10 May 2017.

  The outcome of this meeting was that a monthly improvement board would be convened with all key stakeholders and a support and improvement package would be put in place to scrutinize, monitor and secure improvement in the key areas identified during the inspection, namely the Emergency department.

  A further outcome was that the trust would be considered by NHS England and the chief inspector of hospitals to be given 'challenged trust' status. This status provides the trust with additional support from key agencies including NHS Improvement. Shortly after this meeting this status was confirmed and agreed. The trust remains in 'challenged trust' status at the time of writing.

  Monthly improvement boards have continued and are attended by an inspection manager within the Commission.

- We found the trust in breach of several regulations and specifically in relation to Mr. Bingham's case in breach of Regulation 12 (safe care and treatment).

In response to this it was decided through our internal management review process to issue Requirement Notices to the trust on these Regulations including Regulation 12 (safe care and treatment).

These Requirement Notices are issued as part of the report publication process and the trust has 28 days in which to submit an action plan for addressing these areas.

However in addition we formally wrote to the trust and requested immediate assurance on how they intended to meet the Regulations they were breaching. The trust provided us with a robust action plan which was scrutinised by senior staff within the Commission and also at the monthly improvement board meetings.

- We undertook a follow up unannounced inspection on 22 and 23 June 2017. A copy of the report can be found on our website at the following link: www.cqc.org.uk/sites/default/files/new_reports/AAAG7930.pdf

- In addition to the improvement board we also increased our engagement frequency with the trust and communicate with them at the very least on a weekly basis. This is to share intelligence and receive assurance on progress against the concerns we have raised.

- The decision was also made to directly reference the anonymised incident relating to Mr. Bingham in the inspection report under the effective heading. The incident relating to Mr. Bingham also formed part of our decision making for the rating within the effective domain for urgent care services. The rating for this domain was downgraded from 'Good' to 'Requires Improvement'.

- Since we have received the Regulation 28 report relating to Mr. Bingham, we have held two further management review meetings. These meetings have been attended by our legal team and the Head of Hospital Inspection for the North West.

- The outcome of these meetings is that we have asked for additional information from the trust and other agencies including Greater Manchester Police to better inform our considerations on the issue of whether we may (if at all) need to take any further action against the trust from a civil and/or criminal enforcement perspective.

- When this is provided we will be holding further internal management review meetings to review the information in line with our Enforcement Policy and our Enforcement Decision Tree to make determinations on the issue of any civil and/or criminal enforcement which may be appropriate.

In relation to the specific concerns you raised in your report namely your concerns that the current guidelines for the management of head and neck injury may still be unclear. Based on the information we currently hold we can confirm that the trust has breached Regulation 12(1) (safe care and treatment).

The trust have assured us that they are in the process of considering your report and are considering changes to their guidelines in response to this.

We would expect the trust to review these guidelines as part of their response to your report and we will be receiving a copy of their response. When we receive their response we will review the action the trust has taken in response to your report. This will then form part of the discussion and decision-making in line with our internal processes and specifically in relation to the issue of whether further regulatory action may be warranted.

As outlined above we have issued the trust with a Requirement Notice for Regulation 12(1). The trust has submitted an action plan in response to this and we have accepted this action plan. This action plan and progress against the actions contained in the plan will be monitored the through the monthly quality board meetings and our routine engagement meetings.

To be clear however the existing guidelines meet National Institute for Health and Care Excellence guidance but contains an additional chart. During our inspection we identified a risk that staff were not following guidelines and the trust has received a Requirement Notice in that regard.

We consider the trust's action plan to be robust which in turn mitigates the identified risk. This is being monitored by the Commission, NHSI and NHSE through a monthly quality meeting.

We are assured that any risk is appropriately mitigated through the steps outlined above and the additional work with NHS Improvement and NHS England ensures that the trust is subject to additional scrutiny.

Yours sincerely

Head of Hospitals Inspection North West

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Date: 20/10/2017

Reference number: 5423/HC

Dear HM Coroner

Care Quality Commission ('CQC')
Health and Social Care Act 2008

Re: Regulation 28 report in relation to the death of Mr. Michael Bingham

Thank you for the Regulation 28 Report following the Inquest touching on the sad death of Mr Michael Bingham.

Colleagues in our Adult Social Care Inspection team are responding separately to your Report and the matters of concern which come directly within their remit.

This response relates specifically to the following points raised in your report:

> CQC:
>
> The evidence that I heard was that under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 it is the Registered Persons responsibility to comply with those Regulations. I understand that at present, the Guidance issued by the CQC in respect of those provisions (the Guidance on Providers to meeting the Regulations) does not stipulate how they must comply with those Regulations but does advise that any security provisions must make sure that people are safe whilst receiving care and that premises must be fit for purpose in line with statutory requirements.
> I accept that on the present Regulations it is for the Registered Person to make a risk assessment in relation to internal secure doors and the safety and security that they provide to service users. However, I ask you to review, in light of the evidence I have received in the course of this investigation whether there should be a further issue of regulations or guidance to ensure a consistent approach in respect of the assessment of any safety risk due to falls posed by the use of an emergency door release panel. I also ask you to review your inspection procedures in respect of a Registered Person's compliance with the Regulations in respect of the safety and security of internal secure doors.

Further issue of Regulations and/or Guidance

CQC proposing the amendment of the regulations is unlikely to be the most timely and effective mechanism for change or improvement in this area. The issue at hand is highly technical and specific; regulations are usually set at a higher level, with detailed risks and issues addressed through codes and practice and guidance. In addition, door release mechanisms have not so far been identified as a key safety issue through multiple incidents similar to those involved in this incident; it is very unlikely, despite this latest tragedy, to be seen as a priority for specific legislative change at this time.

The CQC website already signposts the relevant Health and Safety Executive (HSE) guidance (*Health and safety in care homes (2014) - HSG 220*) alongside our own guidance to providers on how they can meet the regulations.

We have contacted the HSE to check that we are still signposting to the most current guidance from them in relation to secure doors and gates in care homes. They have responded to say that they have no current plans for revising the guidance referred to in the previous paragraph. The earliest that they would review it would be in the next financial year 2018/19. We will continue to signpost the most up to date information and guidance available to providers who are registered with CQC.

Review of Inspection procedures

Premises safety forms part of the assessment we make of care home providers when we ask our key question 'Is the service safe?' There is a Key Line of Enquiry in our inspection assessment framework that asks: *How are risks to people assessed and their safety monitored and managed so they are supported to stay safe and their freedom is respected?* Inspectors explore how premises and the safety of communal and personal spaces are checked and managed to support people to stay safe when following this line of enquiry. As noted in your report, neither the regulations nor our assessment frameworks are prescriptive on how providers who are registered with us should do this. This is because each service is different and the needs of the people they care for and support can and do vary substantially. Providers must necessarily assess risks in different ways and focus on different issues in a proportionate way at all times taking into account the individual circumstances of their particular service as well as the people who use it.

However, we do recognise that there are lessons to be learnt from this sad death. We always consider and learn from Regulation 28 reports and their recommendations in our Regional Regulatory Risk Meetings. Within that forum we will explore how we can better inform our inspectors about the risks and issues identified as a result of this incident, and discuss how best to do so in our internal Continuous Improvement, Quality and Evaluation Group. We will also consider whether associated changes are needed when we begin planned work on the next iteration of our assessment framework, which is due to commence later this year. We will also explore how they can inform a planned checklist for use by inspectors when inspecting the safety of care homes premises.

In doing all of this we must however have regard to the fact that as with most regulators (and in accordance with our regulatory remit) CQC highlights breaches of the regulations to a Provider and requires compliance, but does not tell them *how* they

must do so. That is for the Provider and/or Registered Manager to decide. It would not be appropriate for CQC to direct or micro-manage the day to day work of Providers.

Please do not hesitate to get in touch if you have any further questions. We will be happy to assist.

Yours Sincerely,

David James

(signature typed, 20/10/2017)

Head of Adult Social Care Policy
Care Quality Commission

Email

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HM Coroner
Manchester South
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1 Mount Tabor Street
Stockport
SK1 3AG

3 October 2017

Care Quality Commission (CQC)
Our Reference: MRR1 - 3574600002

Dear HM Coroner

Prevention of future death report following inquest into the death of Michael BINGHAM

Thank you for sending CQC a copy of the prevention of future death report (Regulation 28) issued following the death of Mr Bingham.

As you are aware the CQC Inspection Team attended the Inquest and were represented by Mr Harrison of Counsel. For that reason we won't repeat here the content of the letter(s) which were submitted on our behalf by the CQC Legal Team in advance of the Inquest.

The registered provider Harbour Healthcare has copied CQC into correspondence sent to yourself confirming the action they have taken following the death of Mr Bingham and the additional action they have taken in response to your Regulation 28 Report.

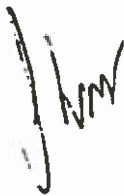
We will be undertaking a further inspection of the service over the coming weeks to verify that screech alarms or key box panels have been installed to internal doors at Hilltop Court Nursing Home, as detailed in the registered provider's response to the Regulation 28 Report.

The registered provider has advised that all other Harbour Healthcare's care homes have been fitted with screech alarms. This will be verified by CQC at the next inspections of each of their locations.

Following the Inquest we also held an internal review of the facts in relation to Mr Bingham's fall at the care home and concluded that there was no evidence to indicate that a regulatory breach on the part of the Registered Provider and/or Registered Manager had occurred which had then led to Mr Bingham's fall.

Should you require any further information then please do not hesitate to get in touch.

Yours sincerely



Sheila Grant
Head of Inspection Adult Social Care (North Central)

319-2017
Response

Stockport NHS
NHS Foundation Trust

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Our ref. MBi 1919
Your ref. 5423/HC

15 September 2017

Miss A Morris
H. M. Assistant Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Miss Morris

Re: Michael BINGHAM (Deceased)

Thank you for your letter of 31 July 2017 concerning the inquest of the above named patient. As always, I am grateful to you for highlighting your concerns and for providing me with an opportunity to respond.

As per your regulation 28 report to prevent future deaths I will comment on the one topic which was raised for this Trust. You raised your concern that the Guidelines for Head / Neck injuries that had been amended following this incident may continue to provide a lack of clarity as to when CT scans should be considered in those aged over 65 years and with dementia or other cognitive impairment. The word 'confusion' remained under the general guidance but had been changed to 'dementia' under the guidance for those who are already being subject to a head scan.

The Emergency Department have further reviewed the guideline following discussions held at the inquest and following the information within your regulation 28 report. We have further amended the guideline which I enclose for your information.

I hope that this response addresses your concern and provides you with the assurance that the Trust is committed to improving the quality of care we give to all our patients. Please do not hesitate to contact me if you have any further questions regarding this matter.

Yours sincerely

Ann Barnes
Chief Executive

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