HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

Mr Zafar Siddique
Black Country Coroner's Court
Jack Judge House
Halesowen Street
Oldbury
West Midlands
B69 2AJ

BY POST AND EMAIL

03 January 2020

Care Quality Commission
Our Reference: MRR1-6821115121

Dear HM Coroner,

Prevention of future death report following inquest into the death of Shannon Quinn.

Thank you for sending CQC a copy of the prevention of future death report issued following the death of Shannon Quinn (Miss Quinn).

Background:

In terms of the actions already undertaken by the CQC following receipt of information concerning the death of Ms Quinn, CQC first became aware of Miss Quinn's in January 2019 when the provider notified us of her death. Upon receipt of the evidence bundle for Miss Quinn's inquest on 30 April 2019, we reviewed the evidence for the purpose of informing our monitoring of the service. On that basis we identified potential ongoing risks for people living at Oak House. These risks related to the management of self-harming behaviours and suicidal ideation. In response, we began a comprehensive inspection of the service on 15 May 2019. Over the course of the 15 and 16 May 2019, inspectors visiting the service identified serious concerns in relation to the following:

1. Risk management.
2. Incidents and allegations of abuse not being reported to external agencies.
3. Lack of managerial or provider oversight at the service.

The seriousness of the concerns led to us taking urgent enforcement action on 17 May 2019 imposing conditions on the provider's registration pursuant to section 31 Health and Social Care Act 2008 (HSCA). Further inspection visits were conducted on the 21 May 2019 and 4 June 2019. In response to the information and evidence gathered during those further visits CQC took further urgent enforcement action and imposed additional conditions dated 22 May 2019, also pursuant to section 31 HSCA. We then met with the provider on the 27 June 2019 to discuss our concerns.

A report of our findings from this inspection can be found at https://www.cqc.org.uk/location/1-1249253242. You will note that the provider was given an overall rating of Inadequate and placed into special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

An inspection of the other active Camino Healthcare Limited service, Cromwell House, was also undertaken in response to the findings at Oak House. This inspection took place on 13 June 2019. The provider was given a rating of Requires Improvement for this service.

We intend to re-inspect Oak House in line with our inspection schedule. Whilst we cannot disclose the date of our next inspection, we can inform you that we will shortly be undertaking another inspection of Oak House to assess improvements made and action taken to meet the conditions placed on the provider on 17 May 2019. In the meantime we continue to monitor the service.

In addition, you may be aware from 1 April 2015 CQC is the lead enforcement body for health and safety incidents in the health and social care sector in England following the coming into force of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (RAR 2014). CQC is currently making enquiries into whether criminal enforcement action should be taken in relation to her death. This investigation is ongoing at the time of writing this letter, so I am unable to provide any further updates or outcome at this time.

Specific response to matters of concern identified in your Regulation 28 report

Within your Regulation 28 report, you identified the particular matters of concern. We respond to each in turn below:

1. ***Evidence emerged during the inquest that there was inconsistent sharing of documentation and case notes between the statutory agencies and private sector. In Particular, there was no sharing of***

medical notes/care plans between the Birmingham and Solihull Mental Health Trust and Oak House.

During the inspection of Oak House in May and June 2019, inspectors identified failures in the providers systems to work with other agencies. In particular the inspection identified that a total of 53 safeguarding incidents had not been escalated to the local authority. CQC had also not been notified of these incidents as required by law. We are currently considering enforcement action in relation to this failure to notify us of incidents. These incidents were shared with agencies following the inspection by CQC and the provider.

At the next planned inspection of Oak House, we will review how the provider shares information and works alongside external agencies to review if these systems have improved.

At our next meeting with Birmingham and Solihull Mental Health Foundation Trust we will discuss with the senior leaders how information is shared with private providers who take patients from the trust and what action has been taken to ensure essential information is been shared.

Additionally, at our next inspection of the Trust we will check that information sharing has improved.

2. ***There was inconsistent and minimal training provided to Oak House staff in respect of managing SQ's Complex needs by the Mental Health Trust.***

At the most recent inspection of Oak House in May and June 2019, we identified that staff did not always receive training to enable them to support people effectively. The report states:

'Staff did not receive training and support that provided them with the skills and experience required to support people effectively. One member of staff told us, "The trainings not the best". Staff felt ill equipped to support people with their complex mental health needs. One member of staff told us, "They [the provider] sold this as a rehabilitation unit but then placed people who are not suitable for rehabilitation. They [people] are too complex and the training doesn't match the people we have here".

In response to our inspection findings, Camino Healthcare Limited submitted an action plan that detailed their intention to review the training provided to staff. We will follow this up at our next scheduled inspection to ensure that sufficient action has been taken to improve the training provided to staff.

3. ***There was a lack of a Joint multi-disciplinary/trust care plan and insufficient contact with the care co-ordinator due to difficulties in***

travelling to meet the patient outside of the normal trust area and staff sickness absence.

At our last inspection of Birmingham and Solihull Mental Health Foundation Trust in November 2018, we rated the Mental Health Crisis and Health-based place of safety as requires improvement. We found that the service did not have sufficient staff and their caseloads were high. We also found that staff did not respond quickly when patients contacted them, and we found that patients had to wait to be seen. Our report found the team worked well as a multi-disciplinary team and with relevant organisations.

The local inspection team meets regularly with leaders of the Trust and will at their next meeting be discussing with the Trust how they currently liaise with organisations that take patients outside of their normal catchment area. We are planning an inspection of the trust in 2020 and will follow this up at that inspection to ensure action has been taken to improve coordination of patient care when patients are out of area.

4. ***There was an escalating risk of use of ligatures and incidents of self-harm and little if any measures were introduced to try and provide a ligature free environment.***

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires that providers must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks.

By way of background, at the inspection of Oak House in May and June 2019, we identified that a Ligature Risk Assessment had been completed in the weeks following the death of Miss Quinn. This identified that although no remedial action was required to the environment, consideration should be given to other measures that may improve the safety of the environment. At the inspection, we found that these suggested considerations had not been implemented and had the potential to pose a risk to other service user's at Oak House.

As a result of this, we took urgent enforcement action that required the provider to seek the advice of an external mental health professional in risk assessing the environment and required them to act on the findings of this audit. The provider took this action on 29 and 30 May 2019. For your information, the condition placed on the provider at this time was as follows:

By 5pm on Friday 31 May 2019, you must have instructed an independent mental health professional to undertake a risk assessment of the environment in relation to the risks of service user self-harm and suicide. You must inform CQC in writing by 5PM on Friday 31 May 2019 of the independent mental health professional you have instructed and the date the risk assessment will take place. The risk assessment must include areas of concern that you must address, including,

ligature risks. You must provide CQC with a copy of the risk assessment and actions taken by you as a result of the risk assessment.

We are aware that there are only currently three people living at Oak House, and that these people do not present risk of self-harm or suicide. However, at the next scheduled inspection, we will review the actions taken in response to the external professional's audit, and review if the provider has systems to regularly assess the safety of the environment for the remaining service users.

5. ***The patient observation level of five minutes was introduced to minimise risk of self harm but not adhered too.***

As noted above, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that providers must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks.

At the inspection of Oak House in May and June 2019, we identified further serious concerns in relation to the management of risk, specifically where service users were at risk of self-harm or suicide. We identified that for some people, there were no risk assessments providing guidance to staff on how to ensure people's safety. Where risk assessments were in place, these lacked details and we found that staff were not applying the guidance provided to them consistently.

In response, we took urgent enforcement action and imposed the following condition on the provider's registration:

'By 5pm on Monday 20 May 2019, you must have carried out a review of all service users who have a history of self-harm or suicidal ideation and ensure that risk assessments are in place. The risk assessments must ensure there is clear guidance for staff of the actions they must take to ensure each service users' safety regarding self-harm or suicidal ideation. The risk assessments must include an assessment of the environment and how any identified ligature risks will be addressed.'

We reviewed the provider's compliance with this condition on 21 May 2019 and found that the provider had implemented these risk assessments. This condition remains on the provider's registration and we will further review their compliance with this at the next scheduled inspection.

6. ***Evidence emerged during the inquest that there had been minimal training for Oak House staff in performing resuscitation on patients. The training received included general first aid training by e-learning.***

As you may be aware the fundamental standards regulations we inspect against do not prescribe what particular training providers must provide to their staff, nor in what format. However, registered providers must ensure that:

Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

In the case of Oak House and its inspection, we found that the provider had not ensured that staff had received training relevant to their role and the needs of the service user's they were supporting. In response, the provider submitted an action plan that detailed their plan to deliver new training to staff. We will follow this up at our next scheduled inspection taking account of this particular matter of concern to ensure that lessons are learnt, and sufficient action has been taken to improve the training provided to staff.

We hope this letter fully clarifies the action we have taken to date as well as the ongoing regulatory activity and future monitoring and inspection action we intend to take in relation to Oak House and the providers Camino Healthcare Limited and Birmingham and Solihull Mental Health Trust in relation to the matters of concern you set out in your report.

If you do have any queries, then please do contact us using the below:

By email: CQCInquestsandCoroners1@cqc.org.uk

By post: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please include the reference number MRR1-6821115121.

Thank you in advance for your assistance.

Yours sincerely

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[redacted]
Head of Inspection