Care Quality Commission

CQC South
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

24 June 2022

HM Coroner Ian Arrow

Re: Regulation 28 response re Mr Glen MacMartin

Dear HM Coroner Arrow

We write to provide the formal response of the Care Quality Commission (CQC) to the Regulation 28 Preventing Future Deaths report made by HM Coroner Ian Arrow following the inquest into the death of Glenn MacMartin ('the Regulation 28 Report').

In the Regulation 28 report HM Coroner raised the following concerns:

1. The deceased was accommodated in a care home that was subsequently formally closed due to poor service
2. Review the selection and monitoring of care home provision and care given by private care home providers who are funded by Devon Partnership
3. Review what actions are taken when care homes are closed to ensure lessons are learnt from such closures.

In our formal response to the Regulation 28 report the CQC deals with each concern in turn and sets out what action it has taken to date to address the concerns and/or what actions we are proposing to take to address them.

1. The deceased was accommodated in a care home that was subsequently formally closed due to poor service

Mr MacMartin was accommodated at Annette's Care on 7 September 2018. On that date the service was rated good. Following a comprehensive inspection on 20 March 2019 the CQC rated Annette's Care as Inadequate overall and subsequently took enforcement action that resulted in the cancellation of Annette's Care Limited, and the closure of the care home, Annette's Care. CQC working closed with the local

authority during this period. The circumstances of Mr MacMartin's death are of great regret to the CQC and we offer our condolences to Mr MacMartin's family.

The CQC received low level information of concern in relation to the service location Annette's Care. Between October 2018 and December 2018 there were two concerns raised. On each occasion CQC reviewed the information and assessed the risk to service users to inform what action CQC should take. In line with CQC methodology at the time we decided not to take regulatory action following reassurances that we received from Annette's Care, Plymouth County Council and the Local Authority Adult Safeguarding Team. In line with our methodology in relation to low level concerns, we noted those areas of concern to inform a future inspection. CQC undertook a comprehensive inspection of the service in March 2019 following receipt of further concerns.

These concerns came from the inspection in February 2019 of a different location owned by the same Registered Provider. That inspection resulted in the CQC taking civil enforcement action against the Registered Provider. In light of this information a decision was made to inspect Annette's Care in March 2019. The comprehensive inspection looked at all five key questions (safe, effective, caring, responsive and well led). The inspection methodology included speaking with and pathway tracking the care of Mr Glenn McMartin. The CQC found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated Inadequate overall. A copy of the report can be found on our website at www.cqc.org.uk/Annette'sCareLimited

The Local Authorities have a statutory duty to investigate allegations of abuse in line with their legal responsibilities pertaining to the Care Act 2014. Therefore, following the inspection, the CQC immediately spoke with Plymouth City Council to share a summary of their inspection findings as well as to raise safeguarding alerts, of both an individual and whole service nature. One of those individual safeguarding alerts related specifically to Mr. Glenn MacMartin.

As part of CQC methodology, CQC also undertook an initial assessment of the specific incident concerning Mr McMartin to determine whether there were reasonable grounds to suspect that a criminal offence may have been committed by the provider Annette's Care Limited under Regulations 12(1) and 22(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We determined there was insufficient evidence of provider level failure to provide safe care and treatment under Regulation 12(1) resulting in avoidable harm to Mr McMartin or exposing him to a significant risk of such harm occurring.

The CQC has undertaken an internal review of the actions it took in relation to Annette's Care Limited and the case of Mr MacMartin. We are satisfied that the decision taken to inspect Annette's Care was timely, proportionate and justified, and complied with CQC methodology. We are also satisfied that the determination not to proceed to a formal criminal investigation following the initial assessment was also proportionate, justified and in line with CQC methodology. These assessments will be reconsidered in light of any recommendations made or findings from the joint agency Learning Event, which we refer to later in this response.

Review the selection and monitoring of care home provision and care given by private care home providers who are funded by Devon Partnership.

The CQC was established on 1 April 2009 by the Health and Social Care Act 2008 ('the Act'). The CQC is the independent regulator of Healthcare, Adult Social Care, Hospital and Community Trusts and Primary Care Services in England. The CQC also protects the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act. The Act introduced a single registration system which applies to both Healthcare and Adult Social Care Services.

We recognise that the Local Authority also has a role in selection and monitoring of a service, as well as in relation to safeguarding. We anticipate the Local Authority will summarise this role in their response to the Regulation 28 report.

We also recognise the importance of ensuring the cooperation and collaboration where appropriate between CQC and the Local Authority. In practice, as in this case, CQC proactively attend regular meetings with the Local Authority to share information about registered services. This forms part of the intelligence we use to inform CQC decisions on whether and what regulatory actions CQC might consider. CQC also attend safeguarding meetings where safeguarding issues have been identified and contribute to the safeguarding plan where appropriate.

Once registered with the CQC, Registered Providers such as Annette's Care Limited are required to comply with conditions placed on their registration and to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ('Regulated Activities Regulations 2010') and the CQC (Registration) Regulations 2009 ('the Regulations'). The Regulations set out the fundamental standards of quality and safety that service users have a right to expect. The Regulated Activities Regulations 2010 were replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (RAR 2014) ('the Regulated Activities Regulations 2014') which came into effect from 1 April 2015. The Regulated Activities Regulations 2014, sometimes called the Fundamental Standards Regulations, include a requirement on the registered provider to undertake risk assessments, prior to and upon arrival of a service user, and on a continuing basis thereafter, to ensure that the provider is capable of and is meeting, the needs of service users, including providing safe care and treatment under Regulation 12(1) RAR 2014.

The Regulated Activities Regulations 2014 apply to all Registered Providers in setting out the duties they must meet and does not distinguish between private or Local Authority care services.

The CQC are responsible for monitoring, inspecting and regulating services to make sure they meet the fundamental standards of quality and safety including, where appropriate, taking civil and/or criminal enforcement action in line with CQC's published enforcement policy. The Decision Tree is the judgment framework tool used to determine the seriousness of breaches of Regulations, and to determine the appropriate regulatory action CQC should take, in accordance with CQC's published Enforcement Policy. Additionally, the CQC publish our findings which includes ratings.

Devon Partnership Trust (DPT) were the responsible Commissioner for Mr Glenn MacMartin's care and support, and for the ongoing review of the quality of that care and support.

The CQC have undertaken an internal review of the actions taken by CQC in relation to Annette's Care Limited and in relation to the care provided to Glenn MacMartin. On the basis of that internal review CQC is satisfied its actions were taken in line with CQC methodology, were timely, justified and proportionate. In line with our information sharing and safeguarding procedures those actions included raising individual safeguarding alerts with Plymouth Adult Safeguarding which is the lead agency for adult safeguarding under the Care Act 2014.

The CQC are participating in a 'learning event' with Devon and Cornwall Police, Devon Partnership Trust and Plymouth County Council (Commissioning and Adult Safeguarding) as part of our continuing effort to improve coordination of CQC and Local Authority actions, and to learn any relevant lessons, individually and/or collectively. Following the conclusion of the learning event we will consider any recommendations. Unfortunately, the family have not been available to participate which has had an impact on the progress of the learning event. We look forward to meeting with the family when they are available.

Review what actions are taken when care homes are closed to ensure lessons are learnt from such closures.

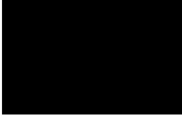
In line with the CQC's enforcement policy, civil enforcement action was taken and CQC issued a Notice of Proposal (NOP) to cancel the providers registration on 23 April 2019. The Registered Provider submitted representations to the CQC to appeal the proposal to cancel registration. The written representations were not upheld and the Notice of Decision (NOD) was served on 23 August 2019. The Registered Provider appealed to the First Tier Tribunal (Care Standards) in October 2019. Their appeal was refused and did not proceed to a hearing because it was out of time. The cancellation of the provider's registration took effect on 28 February 2020.

As part of the internal review undertaken in this case, CQC considered whether it revealed areas for improvement in CQC's monitoring, inspection and/or enforcement methodology. We determined that the case did not reveal gaps or areas for improvement and that CQC's actions were timely, justified and proportionate. In particular, partner agencies (Local Authority and Commissioners) made the necessary contingency arrangements to find residents living at Annette's Care alternative homes; during this process the CQC worked closely with our partner agencies.

CQC seeks to continually improve monitoring, coordination and the sharing of information with Local Authority and Commissioners. In relation to this case, CQC will participate with the 'learning event' taking place with the local authority and Devon Partnership Trust.

Once the learning event has taken place and any recommendations or learning has been identified and agreed, we would be delighted to share such recommendations and learning with HM Coroner Arrow.

Signed



Head of Inspection

Adult Social Care, South Network