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HM Assistant Coroner Henley
Newcastle upon Tyne and North Tyneside Coroner

Recipient: northtynesicecoroners@newcastle.gov.uk

24 February 2022

Dear HM Coroner Henley

Regulation 28 Report following the inquest into the death of David Michael O'Brien [redacted]

We write further to the Regulation 28 report that you made following the inquest into the death of David Michael O'Brien.

The Care Quality Commission (CQC) has considered carefully the concerns raised at Section 5 of your Regulation 28 report. Specifically, it has done so to inform its assessment not only of potential criminal enforcement arising from the specific incident of, and circumstances relevant to, David O'Brien's death; but also of potential regulatory action to protect service users from ongoing risks as identified in your Regulation 28 PFD report.

In terms of potential criminal enforcement arising from the death of David O'Brien you will be aware that CQC has a power to prosecute for failures to provide safe care and treatment resulting in avoidable harm or a significant risk of exposure to avoidable harm, under Regulations 12 and 22 Health and Social Care Act 2014. Prosecutions can be brought against registered providers, individual registered managers and directors of corporate providers. The elements of the offence that the Commission must prove in the context of this case to bring criminal enforcement action against a registered person under Regulation 22 RAR 2014 are as follows:

(1) There was an incident of avoidable harm to a service user or a service user was exposed to a significant risk of avoidable harm; and
(2) The avoidable harm or significant risk of exposure to avoidable harm must have resulted from a failure to provide safe care and treatment in breach of Regulation 12 RAR 2014; and
(3) The breach was the responsibility of the *Registered Person* – Registered Provider and/ or Registered Manager.

In this case, CQC undertook two initial assessments of information and evidence obtained to determine whether there were reasonable grounds to suspect an offence of avoidable harm to David O'Brien under Regulations 12 and 22 RAR 2014, and so whether to undertake a formal criminal investigation. The first was undertaken prior to the inquest following initial enquiries made.

The second took place after the inquest and took account of the evidence gathered during the coronial investigation and specifically the concerns raised at points 1-8 of your Regulation 28 report. In both cases the CQC concluded there were no reasonable grounds to suspect an offence under Regulations 12 and 22 RAR 2014 and no formal criminal investigation was undertaken.

In terms of CQC's other regulatory functions, in between inspections the CQC continually monitors all the information we hold about a service. We receive and review information and intelligence from a range of sources, including from HM Coroner. If the CQC receives any information of concern about a service provider our aim is to respond as quickly as possible, assessing the risk and identifying the appropriate action to take.

In this case, we have reviewed the information received by you, both in terms of the evidence gathered during the coronial investigation and shared with CQC, and the concerns set out in section 5 of your Regulation 28 PDF report along with information we hold about the service. CQC has identified a number of areas where Springfield should make improvements to protect service users from potential continuing risks. We will be holding an internal management review meeting to consider what further action may be required including when an inspection of Springfield is carried out and the focus of any inspection to include the concerns raised at section 5 of your PFD report. We will inform you of the action we propose to take once our internal management review process is complete.

We kindly thank you for your report. If you have any questions please do not hesitate to contact me [redacted]

Yours sincerely

[redacted]

Head of Inspection
London ASC