CQC response to Regulation 28 report – Action to Prevent Future Deaths

Report details
Report by [redacted] To Dr Karen Henderson, HM Assistant Coroner for Surrey In respect of the inquest of Connor Wellsted
Background
I have prepared this report in respect of the Regulation 28 report – Action to Prevent Future Deaths, received 17 May 2022 – relating to the death of Connor Wellsted on 17 May 2017. I have been asked to do so in order to outline the action proposed, or taken, by the Care Quality Commission ('the CQC') with responsibility for the regulated activity Treatment of Disease, Disorder and Injury (TDDI) in Children's Homes, including The Children's Trust (TCT) where Connor died. I am employed as an interim Children's Services Inspection Team Manager in the National Operations Directorate of the CQC. This response will explain the actions already taken by the CQC and explain the rationale for no further action being taken. The coroner's concerns in section five on page two of the Regulation 28 report are as follows: 1. The cot 2. Monitoring of Connor during the night 3. Probity and Investigation by the Children's Trust – Tadworth 4. Senior management, Children's Trust - Tadworth
The cot
The R28 report states: *'The cot Connor's was allocated was nine years old, used infrequently and had not had a yearly servicing for the previous five years. There was no guidance or clarity as to how the padded boards/cot bumper should have been placed around the wooden frame of the cot in circumstances whereby the foster parents did not wish the cot to be padded.* *It is likely the padded board (1m long, 40 cm wide with a soft side and a rigid side) was inappropriately and inaccurately placed on the wooden frame of the cot and as its top edge was without Velcro it could not have been attached to the cot leaving it loose with the result that it dislodged entrapping Connor across his neck.'* **The CQC response:** The cot used for Connor during this admission was not a standard piece of equipment used by staff at TCT and they were unfamiliar with its use. This type of cot is no longer in use at TCT and all specialist cots have been replaced with equipment compliant with current bed standards. *(BS EN 50637:2017 – Medical electrical equipment – Particular requirements for the basic safety and essential performance of medical beds for children).*

There was also evidence of staff failing to follow the care plan which stated to use the cot without the padded bumpers, in line with the foster carers' wishes and to allow for maximum visibility for both Connor and staff, as three of the bumpers remained in situ. One of the recommendations from the root cause analysis (RCA) was regarding the implementation of care plans and the stipulation to discuss with the shift leaders if there were concerns around the adherence by staff to any instructions in the care plan.

Since then, there have been a small number of incidents resulting from care plans that have not been fully adhered to, that have been appropriately notified to the CQC. We have seen evidence where proper investigation and action has been taken by TCT on each occasion, including staff being required to write reflective accounts, undergo additional training and/or a period of observed practice, and where necessary, disciplinary action.

The CQC have carried out three inspections of TCT since Connor's death as follows:

- November 2017 – this was a comprehensive unannounced inspection looking at all five key questions of whether TCT is Safe, Effective, Caring, Responsive and Well-led. We rated outstanding by the CQC's Adult Social Care team.
- January 2020 – comprehensive announced inspection looking at all five key questions of whether TCT is Safe, Effective, Caring, Responsive and Well-led. This inspection was carried out by the CQC's Children's Services Inspection Team and was aligned with Ofsted. Both the CQC and Ofsted rated outstanding.
- May 2021 – targeted unannounced inspection by the CQC's Children's Services Inspection Team looking at the key question of whether TCT is Safe, there was no change to the rating.

Audits and children's records were reviewed in all three inspections and we did not find any evidence of care deviating from that stipulated in care plans. We saw examples of how learning from audits was shared with multi-disciplinary staff across all seven houses.

Monitoring of Connor during the night

The R28 report states:

'Connor had no regular or direct visual supervision during the night (other than to open the door of his room to check if there was a smell) despite the request of his foster parent to check in circumstances whereby in other parts of the Trust regular visual inspection was the norm.'

The CQC response:

The RCA shared with the CQC states that Connor was not observed overnight when at home and he was assessed by the multi-disciplinary team at TCT on admission, as being physically and medically well. This led to the decision that there was no clinical indication for overnight observations. The needs of the children staying in different parts of TCT vary. For example, Chestnut House cares for children with the most complex of needs, including medical. Connor was placed in Maple House for his rehabilitation and did not have any medical needs at that time.

TCT have introduced a clear and comprehensive Sleep Monitoring Policy, which was signed off and implemented in 2018 and updated in 2019. The policy has been further updated and renamed Frequency of Monitoring and is due to be signed-off in July 2022. Records reviews during each of the inspections indicated staff understanding of the policy and adherence in children's care plans where the requirement of overnight monitoring is based on clinical need and individualised to each child.

TCT have taken action in relation to overnight monitoring appropriate to what we would expect of them.

Probity and Investigation by the Children's Trust - Tadworth

The R28 report states:

'The Police and the coroner's service attending the Trust shortly after being informed of Connor's death were not fully informed of the circumstances of his death. The scene had not been preserved. They were not told of the position Connor was found, that he had been dead for some time (likely hours) or that the padded board was initially found across his neck and that it required force by either one or two nurses for it to be pushed down to be removed.

Connor's death was sudden and unexpected, and the senior management of the Trust (chief nurse and medical director) were concerned at the time the role the padded board may have played in Connor's death. However, they did not keep a copy of Connor's medical records, nor did they undertake their own initial internal enquiries, or inform the relevant statutory bodies of their concerns. Furthermore, they arguably misled the CQC as to the circumstances of Connor's death.

Likewise, the pathologist who undertook the autopsy on Connor was not informed of the circumstances of his death thereby preventing a forensic post-mortem to have taken place to establish the role the cot bumper may have played in his death. In addition, the Trust engaged an expert opinion from a forensic pathologist without fully informing him of the position the cot bumper may have played in Connor's death.

The Trust undertook several Serious Investigation reports, the first of which was six months after Connor's death. These reports did not acknowledge or address the role the cot bumper may have played in Connor's death despite evidence from multiple witnesses indicating it was likely to be significant.'

The CQC response:

The statutory notification shared with the CQC on the day Connor died, described his position in the cot and stated that the padded bumper was found against his chest, rather than his neck.

A discussion between the registered manager of TCT and the CQC relationship owner in the Adult Social Care directorate suggests the decision to delay the initiation of the RCA was deliberate and was documented as follows:

'I called [redacted] the RM at the service. HD states that yesterday they had the documents back from the coroner's office so expects a conclusion from the coroner's office shortly. In the meantime, as they now have the documents needed, they will start the internal investigation.'

The internal root cause analysis report concluded on 20 December 2017 and identified a number of actions to address weaknesses in practice. Improvements in these areas were evident at the subsequent comprehensive inspections. As identified in the coroner's R28 report, the RCA did not consider the cot bumper as a causative factor in Connor's death. The lessons learned and recommendations were predominantly regarding overnight observation.

All statutory notifications received by the CQC from TCT since I became the relationship owner in 2018, have been followed up with appropriate and robust investigation reports, complete with details of actions taken and improvements made.

Senior management, Children's Trust - Tadworth

The R28 report states:

'The current senior management team have not acknowledged there was a lack of transparency and openness as to how Connor died, or that the Trust did not properly investigate his death or inform the relevant statutory bodies of the circumstances of his death giving rise to concern
of an ongoing lack of insight that institutional learning around serious incidents has not been accepted by the Trust.

As a consequence, there is a need to introduce and develop robust clinical governance processes and systems to reassure the public and supervisory statutory bodies that they will be informed of any future adverse events and they will be investigated with openness, candour and transparency.'

The CQC response:

We have seen evidence in monitoring and engagement work, as well as during inspection activity, of a learning culture at TCT. Recommendations made in the 2020 report had been implemented at the time of the unannounced targeted inspection in 2021. Since becoming the relationship owner in 2018, the senior leadership team at TCT have always been receptive and responsive to challenge and proactive in providing information to demonstrate how improvements have been made in response to incidents, complaints and inspection findings.

The latest comprehensive inspection in January 2020 found the following:

'There was an open and transparent culture amongst staff and leaders to identify, report and learn from incidents and near misses. Incident reports were detailed, and investigations were thorough with clear analysis and action planning as a result.

Lessons learned were shared with all staff and houses meetings, team away days and a monthly governance blog on the intranet. A tracker was in place to monitor when actions were completed and by whom. This demonstrated a commitment for staff and leaders to continually improve and make the service as safe as possible for children and young people.

Governance structures, accountability frameworks and monitoring of quality and improvement was strong and well-embedded throughout the service. Staff and leaders at both strategic and operational levels regularly asked themselves, and each other, the five key questions about whether their service was safe, effective, caring, responsive and well-led. We saw good evidence of challenge and seeking assurance to maintain excellence and continually improve.

The service demonstrated well how they strived for continual improvement. They had a comprehensive audit plan which included external as well as internal audits. Areas regularly audited included clinical, medical and psychosocial audits including safeguarding, supervision, care plans and medicines management. Audits were generally very effective in driving progress. Medicines audits, however, were not always effective in highlighting areas for improvement, such as oxygen storage and person-centred PRN protocols.

We saw significant evidence demonstrating the strong culture of learning and how well the service learned from feedback, complaints, and incidents. Feedback from children, young people and their families was actively sought, including through the young person's participation group and the friends and family test (FFT). We saw how staff and leaders were proud of the excellent care they provided to children and were keen to identify how they could do even better. The quality improvement lead was developing an adapted version of the FFT specifically for children and young people to complete, which will be in place by April 2020. This will give children and young people another opportunity to have their voices heard.'

Final comments

The report following the inspection in November 2017 can be accessed by the following link: The Children's Trust_November 2017 report

The report following the inspection in January 2020 can be accessed by the following link: The Children's Trust_Jan 2020 report

The report following the inspection in May 2021 can be accessed by the following link: The Children's Trust_May 2021 report

The inspections completed in the five years since Connor's death, as well as the information available regarding TCT's response to incidents, events and complaints, have all identified safe practice and good leadership and governance. The CQC have not found any evidence to suggest that the concerns raised in the Regulation 28 report, remain as concerns, regarding current leadership, governance or practice.

The CQC will continue to monitor and inspect according our published inspection methodology and continue to respond to any emerging risk identified through notifications or whistleblowing reports.

Signed:	[redacted]
Name:	[redacted] interim Children's Services Inspection Manager
Authorised by:	[redacted] Deputy Director of Multi-agency Operations
Dated:	27 June 2022