Private and Confidential

HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

[redacted]

Dr Karen Henderson
HM Assistant Coroner for Surrey
HM Coroner's Court
Station Approach
Woking
Surrey
GU22 7AP

21 July 2022

Care Quality Commission
[redacted]

Dear HM Coroner

Prevention of future death report following inquest into the death of Matthew John Evans.

Thank you for sending CQC a copy of the prevention of future death report issued following the sad death of Matthew John Evans. I would like to extend our condolences to Mr Evans' family.

Following receipt of the report, CQC contacted Farnham Park Health Group, the provider of The Ferns Medical Practice, to request written confirmation and evidence of the action they have taken to date in light of Mr Evans' death. We also requested any additional action they intend to take in response to the prevention of future death report.

In response to our request, we have received evidence of a significant event analysis, completed on 31 May 2022, and a detailed action plan, laying out the steps the provider is actively implementing in response to Mr Evans' death. Out of the 10 actions identified, the provider was able to demonstrate seven actions have already been completed to date, and the remaining three remain in progress, mainly due to external resources being required.

We are satisfied, at this point, that the circumstances surrounding Mr Evans' death were a specific case and not indicative of widespread poor care on the part of the provider. Whilst we have concluded that improvements could have been made in the care and treatment provided to Mr Evans, it was not unsafe. We are pleased to see the provider has identified areas of improvement in its care and treatment, and we are assured that the actions taken will protect others using the service from harm. At this stage we have decided not to instigate any further action. However, we will continue to regularly monitor the provider and, where

necessary, take regulatory action to ensure patients are receiving a safe service.

As you may be aware, CQC can only take regulatory action against a registered manager or a registered provider, but not when failings of an individual have been identified.

Please also be advised our records showed we were not notified of Mr Evans' death by the registered provider, as was legally required. This failure to report was immediately raised with the provider and we have since received this information. In accordance with our regulatory processes, consideration will now be given as to whether further action is needed to address this breach of regulation for failing to notify us in a timely way.

Please do not hesitate to contact me should you require any further information.

Yours sincerely

[redacted]

[redacted]

Inspection Manager
Thames Valley
Primary Medical Services
Care Quality Commission