Care Quality Commission

HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

HM Coroner
London Inner South Coroner's Court
1 Tennis Street
SE1 1YD

3 July 2017

Our Reference: MRR1-3839024472
Your Reference: 00725-16

Dear HM Coroner,

Response to Regulation 28 Report to Prevent Future Deaths Re: Cedrick Skyers, Ref. 00725-16

Thank you for sending the Care Quality Commission (CQC) a copy of the Regulation 28 Report to Prevent Future Deaths which we received on 10 May 2017 following the death of Mr Skyers, who lived at Manley Court Care Home. We are writing to you with our response to the issues raised within your report.

As you are aware, CQC is currently assisting the Fire Authority with a joint investigation to consider what (if any) criminal enforcement action may be appropriate against the registered provider specifically in relation to the death of Mr Skyers.

We note that you have the authority to publish this response. However, we respectfully ask that whilst the Fire Authority and CQC are considering their respective positions in relation to potential enforcement action that no publication of this letter takes place and that the letter is not provided to any other Interested Person(s).

Manley Court Care Home is based in New Cross in London and is registered to provide personal and nursing care for up to 85 older people. Prior to Mr Skyers' death, CQC had inspected the service on 16 and 17 April 2015 and rated it "Requires Improvement" overall. There was one breach found in relation to staffing levels and the service was issued with a requirement notice. In addition, recommendations were made in relation to supporting staff and storing medicines at the correct temperature. You can find a copy of our report on our website http://www.cqc.org.uk/location/1-127818698/reports.

Prior to the receipt of your report, the CQC became aware of Mr Skyers death via Mr Skyers' son, who told us of his father's death on 14th March 2016. We were informed that on 13 March 2016 Mr Skyers was smoking unattended in the garden of Manley Court when a staff member saw that he had caught alight and alerted other staff who put the flames out and contacted emergency services. Mr Skyers was attended to by paramedics but sadly died later that day at Kings College Hospital.

On the basis of the information received at the time, we carried out a comprehensive inspection following the incident on the 18th and 23rd of March 2016. We found concerns with risk assessments and staffing shortages. Our report is published on our website with a rating of Requires Improvement overall. You can find a copy of our report on our website http://www.cqc.org.uk/location/1-127818698/reports.

The matters of concern raised in your report relate to the registered provider, Bupa Care Homes (ANS) Limited ("BUPA"), and their corporate guidance at the time of the incident giving rise to My Skyers death. We have raised similar concerns about the policy and guidance with BUPA in a written interview under caution document 17 March 2017 and a response from BUPA has been received in writing 14 April 2017. The CQC's PACE questions of concern and related responses are likely to form exhibit evidence in any future possible criminal case.

CQC contacted BUPA on 31st May 2017 to request written confirmation and evidence of the action they had taken following Mr Skyers' death and any additional action they intend to take in response to the prevention of future death report. We received a copy of their Root Cause Analysis Report and the consequent action plan. We acknowledge that Bupa have taken a number of actions to reduce the risk and are reassured by the steps taken so far.

Further to our request, BUPA wrote to inform us that, in the light of your Regulation 28 Report, they are undertaking a further review of smoking risk assessment documentation across all of their care homes. They have stated that the revised process includes an increased emphasis on the use of smoking aprons and supervision. The risk of fire will be explicitly discussed with residents and a refusal by any resident to wear a smoking apron will result in a more comprehensive risk assessment, including consideration of their mobility.

We are planning to undertake a further unannounced comprehensive inspection of Manley Court in July 2017 and will review the documentation and consider whether these steps further reduce the risk to people at the service. Again we would ask that this information not be passed onto any other Interested Person(s).

BUPA do acknowledge that a provider should not override a capable individual's right to make unwise decisions. Following our request, they have written to us to inform us that if a resident who has capacity insists on smoking without supervision or a smoking apron, this will be permitted wherever possible, but will be recorded as being a choice against professional advice. We understand that the smoking risk assessment documents are at the final stages of production and will be shared with you and CQC by the Provider no later than 3 July 2017.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely

Head of Inspection, London South & Surrey
Care Quality Commission