REPORT BY CQC

TO HM CORONER

IN RESPECT OF THE PREVENTION OF FUTURE DEATHS REPORT IN RELATION TO THE DEATH OF MR CHARLES EVANS

Background

1. I have prepared this report in respect of the Prevention of Future Deaths Report in relation to the death of Mr. Charles Evans. I have been asked to do so in order to assist HM Coroner and Interested Persons in understanding the role of the Care Quality Commission ('the CQC') as the regulator for Health and Social settings in England, and CQC's involvement with Hibiscus Housing Association Ltd regarding the risk that future deaths could occur unless action is taken.
2. I am employed as an Interim Inspection Manager in the Adult Social Care Directorate of the CQC. As such I have responsibility for engaging with and assessing the compliance of a range of health and social care services that are registered under the Health and Social Care Act 2008 and placed on my caseload. CQC Inspector responsibilities at the time of Charles Evans death included the assessment of compliance with the fundamental standards of quality and safety by means of inspection visits and to undertake regular engagement with the providers of those services, as the relationship owner. This includes taking action against providers if there were concerns about non-compliance with Regulations and taking action if service users were not being protected from the risk of harm. This decision making was underpinned by the Commission's enforcement policy, methodology and tools that were introduced from 1 October 2014.
3. The role of CQC as regulator, CQCs inspection processes and enforcement action CQC can take is described in Appendix 1.

Appendix 1: The role of CQC as regulator.

Charles Evans

1. CQC had not received any statutory notification from the provider regarding the death of Charles Evans. CQC first became aware of Charles Evans death when we received a Regulation 28 report to prevent future deaths from the Coroner on 25 August 2022. CQC will be considering the failure to notify during their review of this specific incident.
2. When CQC receives information in relation to an incident of this kind, we consider what action we need to take; firstly in relation to whether the information received suggests that there may be ongoing risk which requires CQC to inspect a service and secondly whether the information received suggests the harm sustained was avoidable and may have resulted from a breach of a prosecutable fundamental standard.

3. Following the HM Coroners request for CQC to urgently review/revisit Hibiscus House given the concerns raised and previously identified regarding training in CQCs previous inspection report a decision was taken on 30 August 2022 to inspect Hibiscus Domiciliary Care Agency to look at our key questions of Safe, Effective and Well-Led.
4. CQC have determined that Charles Evans was in receipt of the regulated activity of personal care. CQC are currently gathering evidence to determine whether the serious incident which led to the death of Charles Evans could be a result of Provider failure to provide safe care and treatment, and therefore whether any further criminal enforcement action may be required.

Regulation of Hibiscus House

'*Post inquest, the Coroner noted the CQC Inspection report for Hibiscus House Domiciliary Care Agency dated July 2019 which rated the facility as 'requiring improvement'. The Coroner is concerned to establish whether the service provider put forward an action plan following the CQC Inspection setting out what they would do to improve the standards of quality and safety and whether the CQC monitored any progress towards said plan'.*

1. Hibiscus House is registered with CQC as a Domiciliary Care Agency ("DCA") under the location name Hibiscus Domiciliary Care Agency and is operated by Hibiscus Housing Association Ltd to provide the regulated activity of 'personal care'. Hibiscus DCA provides personal care and support to people who have learning disabilities, physical and mental health needs living in their own homes. Not everyone who uses DCA services receive the regulated activity of personal care. The CQC is not responsible for regulating the quality of the accommodation.
2. CQC carried out their previous inspection on 4 June 2019. The service was rated Requires Improvement overall and in our key questions relating to Safe, Effective and Well-led. It was rated Good in our key questions Caring and Responsive. A copy of this report has been provided in Appendix 2. There was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as whilst there was no evidence of harm, systems were either not in place or robust enough to demonstrate quality and safety was effectively managed, There was also a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for failing to ensure staff received induction and training required. Requirement notices were issued and we asked the provider to send the CQC a report setting out what action they were going to take in order to become compliant with the regulations

Appendix 2: Inspection report 2019

3. CQC received action plans on 8 August 2019 in relation to the breaches identified. These were reviewed by the lead inspector. The provider indicated these concerns would be addressed and completed by September 2019 (Regulation 18 - Staffing) and October 2019 (Regulation 17 - Governance). CQC continued to monitor the location. It is standard practice for CQC to review

progress against action plans for requirement notices at the next inspection or sooner if further concerns arose from our monitoring activity.

4. Inspections scheduled for 4 June 2020 and 21 January 2021 were both cancelled due to the pandemic and changing priorities. A CQC Inspector completed a ‘Portfolio Review Activity’ (PRA) on 15 April 2021 which was a monitoring tool in use by CQC at the time of the pandemic. A PRA enabled Inspectors to record they have reviewed the information CQC held about a service and to make a decision as to whether any further action is required to respond to risk or improvement. The outcome of the PRA was that further monitoring activity was required and consider inspecting. Unfortunately, due to changing priorities during the pandemic, Hibiscus DCA was not inspected.
5. CQC inspected Hibiscus DCA on 7 September 2022 and found concerns around the safety of people’s care. As a result, CQC requested the provider to submit an action plan to address their concerns and held a meeting with the Provider to discuss these following the inspection on 9 September 2022.
6. CQC are currently following their internal enforcement processes to take the appropriate regulatory action to drive the necessary improvements needed and to monitor their progress within their action plan. An inspection report will be published and in the public domain within the next month. CQC will continue to monitor this service, assess the risk and identify the appropriate action to take in our regulatory duties.

The CQC takes the concerns raised seriously and is committed to ensuring health and care services provided to people are safe, effective, compassionate and high quality. The CQC will take action to improve the quality and service of care.

We trust this assists. If you have any further questions, please do not hesitate to contact me.

Report Prepared by [redacted]

Date 02 November 2022