HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

[redacted]

Assistant Coroner
Janine Richards
H.M. Coroners Office
P.O. Box 282
Bishop Auckland
Co. Durham
DL14 4FY

[redacted]

23 October 2023

Care Quality Commission
[redacted]

Dear HM Coroner Janine Richards,

CQC response to prevention of future death report following inquest into the death of Kenneth Rippon.

Thank you for naming the Care Quality Commission (CQC) as a respondent in the prevention of future death report issued following the death of Mr. Kenneth Rippon on 5th May 2022 and for the extension of time to respond to the same. Thank you for agreeing an extension to our timeframe for response this was to allow us time to respond to factual accuracy comments from the trust. Our report has been finalised and will be published on 25 October 2023. We are happy to send you a copy after publication.

In this case the CQC has reviewed the trust's serious incident investigation report and the inquest bundle and has concluded that there is currently no evidence to suggest that there has been a failure by the Registered Person, Tees Esk and Wear Valleys NHS Foundation Trust to provide Mr Rippon safe care and treatment causing Mr Rippon avoidable harm or exposing him to significant risk of such harm occurring. CQC does not have the power to take enforcement action against individuals who are not Registered Persons, except in circumstances where individual directors or members may be held individually liable for the commission of the offence by a registered provider that is a body corporate or unincorporated association, under sections 91 or 92 of the Health and Social Care Act 2008. Those circumstances do not arise in this case.

We note that the concerns are as follows:

1. **The serious incident investigation report in this case was not available until the 24.03.2023, over 10 months since the death and around 8 months outside the NHS framework guidance of 60 days for the completion of such, despite repeated requests and a schedule 5 notice being issued to attempt to obtain a copy of the draft report to inform this investigation, which was not complied with.**

   As well as powers to prosecute in some cases, CQC regulates NHS providers and can require providers to make improvements. In April and May 2023 CQC completed inspections of six of the trust's inpatient and community mental health services and an inspection of the trust's leadership and governance which will be published on 25th October 2023.

   CQC share the concerns of the Coroner. Our own inspection of the trust in May 2023 identified that the trust had significant backlog in their investigation of serious incidents and that this is not in line with NHS standards and processes. We also know that the trust was not carrying out investigations in line with the NHS serious incident framework because investigations were not; open and transparent, preventative, objective, timely and responsive, systems based, proportionate and collaborative and because investigations had not been undertaken in all cases beyond an early learning (72 hour) review

   Through the inspection, CQC gathered evidence to assure ourselves that the trust has taken action to reduce this backlog and prevent reoccurrence. In particular, we have seen that:

   - The trust had processes in place to address the backlog. The trust's newly appointed chief nurse was monitoring progress and had introduced refreshed analysis of each incident in the backlog with weekly meetings to monitor progress.
   - The trust had written to all patients and families involved in the incidents to make apologies for the delay in investigations.
   - All incidents awaiting to be allocated to a reviewer had been placed into 2 cohorts.
   - The trust had employed a patient safety programme lead to manage cohort 1 incidents via an external agency and they had also appointed a number of external SI reviewers.
   - The trust told us that they were assured that despite detailed investigations not being completed for serious incidents, they conducted thorough 72-hour reviews into every incident to ensure

that immediate actions were taken and to reduce the risk of repeated incidents.

To ensure the trust's progress in this matter, CQC have served the trust with a requirement notice, as an outcome of our inspection processes under Regulation 17 (1) (2) (a) (b) Good Governance. This states that:

> *"The trust must ensure that backlogs in the serious incident review, mortality review, incident review and complaints are resolved with pace, and that actions are taken to prevent reoccurrence."*

CQC will monitor that the trust becomes compliant with this regulation and take action as appropriate and necessary in line with our regulatory functions should improvement not be adequate.

2. **The NHS framework sets out clearly a timescale of 60 working days for the completion of investigation reports and highlights the importance of working in an open, honest, and transparent way. One of the key underpinning principles in the management of all serious incidents is that they should be timely and responsive. The purpose of the investigation is to ensure that weaknesses in a system or process are identified to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again.**

   CQC share the Coroner's concerns. These were highlighted to the trust during our inspection in relation to the delays in completion of reports. However, CQC have a limited role in the oversight of the quality of investigations beyond our ability to inspect and take action when there are delays and flaws in a provider's system. The NHS Serious Incident Framework (2015) sets out that "*Providers are responsible for the safety of their patients, visitors and others using their services, and must ensure robust systems are in place for recognising, reporting, investigating and responding to Serious Incidents and for arranging and resourcing investigations. Commissioners are accountable for quality assuring the robustness of their providers' Serious Incident investigations and the development and implementation of effective actions, by the provider, to prevent recurrence of similar incidents."*

   The trust's commissioners are better placed than CQC to act in improving the quality of the trust's investigation processes. The CQC inspection report has been shared with ICB and NHSE and we have raised our concerns directly with the trust.

3. **The delay in the investigation in this case is particularly concerning in a number of respects, not least in that it revealed problems in clinical**

record keeping, risk assessments and the consideration of hospital admission, lack of family/carer involvement, lack of comprehensive mental state examination/assessment including capacity, safeguarding and social needs and medication review and access to services.

As part of CQC's recent inspections in April and May 2023 we shared our concerns in relation to repeated themes arising from serious incidents with the trust. The trust was able to reassure CQC that they were taking revised approaches to improvements in clinical care. The trust evidenced that:

- Following a thematic review of a cohort of serious incidents in July 2022, the trust was able to identify seven key themes across serious incidents and programmes of work were put into place to improve quality and safety in; risk assessment and management; multi-agency working, care planning, record keeping, safeguarding, involvement with patients and carers and medication.
- In July 2022 the trust launched an improvement plan to mitigate the risk of reoccurrence against these common themes. This included; a refreshed electronic patient record system to improve recording and support improved care planning and risk assessment, an increased number of suicide awareness trainers, a suicide and self-harm minimisation group, revised clinical guidance, learning and development enhancements and an improved training matrix, medical emergencies training, enhanced learning opportunities including the organisational learning group, safety bulletins, patient safety clinical huddles and patient safety rapid (72 hour) reviews.
- The trust had also undertaken some thematic work in specific teams where there had been serious incidents in a short time.
- The trust had also used the learning from identifying these key themes to refresh their quality assurance programme from January 2023. The trust's quality assurance programme included targeted audits and reviews including; self-declaration, modern matron quality reviews, practice development reviews, community quality reviews, peer reviews, director visits.

In order to ensure the trust continues to embed these changes and make progress, following our inspections in April and May 2023 CQC have served requirement notices to the trust. We have told the trust that in order to become complaint with Regulation 12 (1) (2) (a) (b) Safe Care and Treatment, they:

> *"Must ensure that learning from incidents, deaths and complaints is effective and embedded and that the risk of repeat incidents is reduced.*

CQC will monitor that the trust becomes compliant with this regulation and take action as appropriate and necessary in line with our regulatory functions should improvement not be adequate."

4. **As a result of the delay in the serious incident Investigation and formulation of an action plan, many of the identified actions required to remedy these difficulties were still being actioned /completed relatively recently.**

   At CQC's inspections in April and May 2023 we investigated the trust's governance procedures and processes. The trust evidenced that they were taking revised approaches to governance systems as they recognised and shared CQC's concerns that the trust have not always completed actions with the required pace to improve safety to patients. In order to ensure the trust continues to embed these changes and make progress, following our inspections in April and May 2023 CQC have served requirement notices to the trust. We have told the trust that in order to become complaint with Regulation 17 (1) (2) (a) (b) good governance they:

   "Must ensure that governance systems and processes are established, embedded and operated effectively to assess, monitor and improve the quality and safety of the services. Using accurate and clear information to make improvements to the safety and quality of services."

   CQC will monitor that the trust becomes compliant with this regulation and take action as appropriate and necessary in line with our regulatory functions should improvement not be adequate.

5. **Further one of the actions upon identification of a serious incident is to obtain, secure and preserve all relevant evidence. In this case the memory capture forms identified as being required in the immediate aftermath of the incident were not taken promptly and were seemingly only taken after I requested sight of them, several months after the incident and therefore when memories had already begun to fade. This was concerning given the identified problem of clinical record keeping at the time of these events.**

   CQC share the Coroner's concerns in relation to the delays in completion of reports. We shared these concerns with the trust during out recent inspection and these are contained within the published inspection report. The report has been shared with ICB and NHSE colleagues for their consideration. However, CQC have a limited role in the oversight of the quality of investigations beyond our ability to inspect and take action when

there are delays and flaws in a provider's system. The NHS Serious Incident Framework (2015) sets out that.

> "*Providers are responsible for the safety of their patients, visitors and others using their services, and must ensure robust systems are in place for recognising, reporting, investigating and responding to Serious Incidents and for arranging and resourcing investigations. Commissioners are accountable for quality assuring the robustness of their providers' Serious Incident investigations and the development and implementation of effective actions, by the provider, to prevent recurrence of similar incidents."*

The trust's commissioners are better placed than CQC to act in improving the quality of the trust's investigation processes.

6. **I am concerned that the extensive and continuing delays in investigating serious incidents may lead to further deaths, as lessons cannot be learnt and improvements made in a timely manner. I am also concerned that the quality of such investigations is compromised by the failure to complete memory capture forms and the passage of time before important evidence is secured.**

   Due to the concerns relating to the backlog of serious incidents, CQC and other stakeholders have continued to monitor the trust's progress with reducing this backlog and preventing reoccurrence of this issue.

   In August 2023, the trust provided CQC with information which showed that the backlog had reduced, and a trajectory is in place with a target date of December 2023 for completion of all historical investigation reports. There is a revised process in place to prevent reoccurrence of this backlog.

   To ensure improvements, CQC will continue to monitor the trust's progress with removing this backlog via the current quality board which meets monthly and is overseen by NHS England due to the trust's ongoing performance issues and its placement in 'system oversight framework segment 3'. This means that:

   > *"For trusts and ICBs in segment 3, NHS England and NHS Improvement regional teams will work collaboratively with them to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved. Through this, we aim to better understand their support needs and agree improvement actions."*

Our inspection report of our findings from our recent inspections will be published on our website on 25 October 2023. CQC are happy to share this with HM Coroner should you wish.

I hope this satisfies HM Coroner that CQC continue closely monitor the progress the trust are making in this respect. Should CQC find improvement does not occur CQC would review the risks associated with this in conjunction with our partners, and in the event of breaches of regulation, we would use our powers to take further action.

Yours sincerely

Deputy Director, Network North.