Department of Health & Social Care

From Minister Whately
Minister of State for Social Care

39 Victoria Street
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020 7210 4850

Mrs Samantha Marsh,
Coroner's Office,
Old Municipal Building,
Corporation Street,
TAUNTON,
Somerset,
TA1 4AQ

26/04/2024

Dear Ms Samantha Marsh,

Thank you for your Regulation 28 report to prevent future deaths dated 31/10/2023 about the death of Evelyn Ann Burcham. I am replying as Minister with responsibility for adult social care.

Firstly, I would like to say how saddened I was to read of the circumstances of Ms Burcham's death, and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter.

Your report raises concerns over electric riser-recline chairs which are commonplace in care home settings, including where residents suffer from cognitive impairment, and the risks of another resident with dementia accessing the controls of the chair(s). The report also raises concerns about the ability, or lack of ability, to 'lock' the remote control and/or find a safe way of storing it so that it is not accessible to anyone who does not have the authority, training or appropriate cognitive function to be able to use it safely.

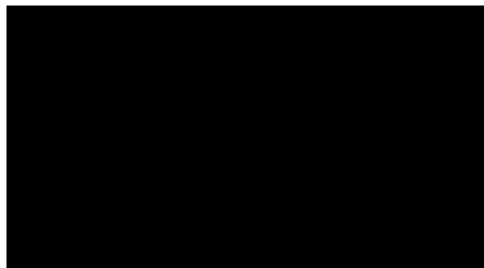
In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission (CQC).

The Department is content that the CQC have discussed the case internally on 06/01/23, including actions taken to date and proposed future actions. It was agreed that further information was required from the provider about the incident. CQC received the information requested and held further internal discussion on 13/02/23. CQC assessed that there was sufficient evidence to refer the incident to the Criminal Enforcement Support Hub (CESH) prior to a Criminal case assessment and progression panel (CCAPP) referral. This referral was made on 15/02/23. This case was accepted as a potential specific incident and assigned an

investigator from CQC's national enforcement team; investigations are now complete, and it has been adjudged that CQC has no basis to take further action as there is insufficient evidence linking this directly to a registered person. The family were made aware of the outcome of CQC's decision and CQC will continue to monitor the provider.

We are also pleased to read that Aria Care along with support from the CQC have moved to use lockable remotes on riser-recliner chairs and agree other actions to prevent a tragic event such as this happening again,

I hope this response is helpful. Thank you for bringing these concerns to my attention.



Helen Whately MP