HSCA Further Information Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

HM Assistant Coroner Miss Caroline Topping, for Surrey

3 April 2024

Care Quality Commission

Dear HM Assistant Coroner Topping,

Prevention of future death report following inquest into the death of Jake Brian Baker

Thank you for naming the Care Quality Commission as a respondent in the prevention of future deaths report issued following the death of Mr. Jake Baker.

CQC has a clear internal process to follow whenever a Regulation 28 report is received, including where CQC are named within report.

In line with the CQC's enforcement and internal specific incident guidance, policies and procedures, a decision review meeting (DRM) takes place. This DRM considers the matters of concern raised, reviews the facts, and gathers additional information where required to inform regulatory decision-making. CQC considers if any potential breaches of regulation may have taken place, and undertakes an initial assessment using our specific incident guidance. In summary terms, this initial assessment enables the CQC to consider and/or determine any appropriate regulatory response in line with CQC's published enforcement policy. More specifically, it enables CQC to consider and determine whether any formal and/or informal regulatory actions are required. This may include monitoring, inspection and/or civil enforcement action to further assess compliance of the provider or protect service users from ongoing risks; and to assess and determine whether there may be reasonable grounds to suspect that a service user(/s) may have sustained avoidable harm or been exposed to a significant risk of avoidable harm, as a result of registered person failure to provide safe care and treatment.

The concerns set out in your report centre on the extent to which Surrey County Council have rigorously reviewed the circumstances of Mr. Baker's death and taken

action to avert the risk of future deaths. Specifically, you identify the following matters of concern:

a) The issues surrounding the inadequacy of Jake's pathway plan have not been addressed comprehensively in the last 4 years. Training for personal advisers is not mandatory and is only now being rolled out. The court was not provided with copies of the training or any protocol in relation to it so as to be assured of the adequacy of the training and its implementation.
b.) The process by which diagnoses of learning disabilities can be obtained remains opaque. There is no protocol in relation to this. The current situation leaves those making decisions in relation to young people struggling to obtain this vital information.
c.) The issue of how the numerous adult social care teams are accessed to obtain adult social care assessments for care leavers leads to confusion and delays. Vulnerable care leavers are at risk of being denied necessary support.
d.) How internal meetings and formal review meetings with other interested parties are informed and recorded is not subject to a protocol and the risk remains that decisions will be taken without adequate information and inquiry as to the risks inherent in those decisions.
e.) Practice standards have not been put in place in relation to risk assessments of care leavers to inform their needs.

Actions taken by CQC following receipt of the information of concern concerning Jake Baker's death

At the time of Mr. Baker's death, CQC did not have any statutory powers in relation to the assessment of Surrey County Council or any other local authority.

On 1 April 2023, the Health and Care Act 2022 gave CQC new powers to assess how local authorities are meeting their duties under part 1 of the Care Act 2014. CQC's role is carried out by way of undertaking an assessment in relation to how local authorities are meeting these duties, then rate and report on the findings. Where CQC find that a local authority is failing to perform its functions under the Care Act to an acceptable standard, CQC must inform the Secretary of State for Health and Social Care.

Between May and November 2023, CQC completed 5 pilot local authority assessments, to test the associated assessment framework, methods and processes. In December 2023, CQC commenced a rollout of its formal local authority assessment programme.

CQC have recently started an assessment process for Surrey County Council. CQC have shared details of the concerns in your PFD report regarding Surrey County Council with CQC's local authority assessment team, to inform their assessment of Surrey County Council.

Your report highlights the failure of Ruskin Mill Trust to ensure Mr Baker's safety when he went home for family contact in 2019. This included a failure to assess and put plans in place to manage the risks posed to Mr. Baker by his diabetic condition during such visits.

On 1 April 2015 the CQC assumed enforcement responsibility for health and safety related serious incidents concerning people using services in health and social care settings in England. This includes where people using services have sustained avoidable harm including death or have been exposed to a significant risk of avoidable harm as a result of a failure by the Registered Person. The 'Registered Person' (RP) is the Registered Provider and/or Registered Manager. Where Registered Providers are corporate bodies (such as limited companies) or unincorporated associations (such as partnerships), individual office holders or members may in certain circumstances be criminally liable under sections 91 and 92 Health and Social Care Act 2008.

The initial assessment and specific incidents guidance processes identified above were initiated following receipt of information of concern following the death of Mr. Baker. Following a thorough criminal investigation, this culminated in CQC bringing a successful prosecution against Transform Residential Limited, which operated Glasshouse College at the time of Mr. Baker's death. This was due to their mismanagement of his diabetes care. On 31 May 2023, the provider pleaded guilty to causing Mr. Baker avoidable harm and was ordered to pay a total of £22,721.04 at Staines Magistrates' Court.

As part of CQC's considered response to any ongoing risk of harm to people living at Glasshouse College, CQC conducted a comprehensive inspection of the service in June 2021. During this inspection, CQC identified significant concerns and 2 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the safety of people's care and the provider's governance arrangements. This inspection resulted in an overall rating of inadequate. Upon CQC's re-inspection of Glasshouse College in March 2022, CQC found the provider had made significant improvements in the quality and safety of people's care. Ruskin Mill Trust Limited were now meeting their legal requirements and CQC gave the service an overall rating of good.

It may also be helpful to the coroner to know that, as part of CQC's broader work around reducing mortality and acting to understand and improve health inequalities for people with a learning disability and autistic people, CQC are working to establish better links with local Learning Disability Mortality Review (LeDeR) teams. This is with a view to establishing relationships which can combine the intelligence held by these teams with CQC's regulatory function.

CQC are also working to improve access to the data that LeDeR hold about the deaths of people with a learning disability and autistic people and have already been given access to a LeDeR data tool which enables CQC to scrutinise themes and trends in a place. Through this work, CQC aim to improve the knowledge and understanding of CQC's workforce by providing advice, learning and tools to enable them to better understand the contributory factors to avoidable deaths and take the right regulatory actions as a result.

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

Yours sincerely

Deputy Director of Operations
Midlands Network