Care Quality Commission
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HM Coroner Jonathan Stevens
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

3 May 2024

Care Quality Commission

[redacted]

Dear HM Coroner Stevens,

Prevention of future death report following inquest into the death of Rose Hollingworth.

Thank you for addressing your Regulation 28 prevention of future deaths report (PFD) to the Care Quality Commission ('the Commission') following the inquest into the death of Rose Hollingworth.

This letter represents the Commission's formal response to your PFD report.

In response to the death of Rosie Hollingworth, the Commission carried out a comprehensive inspection of HomeDotCare Limited in November 2022 with the attached report published in February 2023. The service was rated 'Good' overall.

During this inspection we found action had already been taken to mitigate risk, specifically:

- There was evidence of learning from incidents and improving practice as a result. Examples of this included:
    - Individual fire risk assessments
    - A policy to wake up a sleeping person to check on their health ('sleep protocol')
    - A policy to inform next of kin of when a person had to go to hospital even if person was not admitted and a new orientation training for staff (p8 of the attached inspection report of HomeDotCare Limited:

Assessing risk, safety monitoring and management; Learning lessons when things go wrong).

- Staff training also covered how to respond in an emergency. We asked some new staff if they knew who to call in an emergency and what to do if they found a person unwell. They knew what action to take and said the training had been helpful.
- Staff did not have first aid training and the registered manager arranged this immediately after the inspection for all staff (p10 of the inspection report, Staff support: induction, training, skills and experience).
- There was evidence of a culture of continuous learning and improvement. The registered manager was able to demonstrate learning from incidents which led to improvements in safety and quality of care provided. These improvements included improved training before staff started working with people and the introduction of a 'sleep protocol'. This was a procedure for staff to follow if they found their client asleep on arrival and required them to gently wake the person and ensure they were well. Staff were aware of this protocol and able to explain clearly to us the action they were expected to take
- (p16, Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care).
- As with all services regulated by the Commission, HomeDotCare Limited continues to be monitored and should concerns arise, this could prompt a responsive assessment if necessary. No immediate action is proposed.

Given the action already taken by the Commission, we are reassured that HomeDotCare Limited have responded appropriately in response to the death of Rose Hollingworth. We have not seen evidence to suggest the concerns mentioned in section 5 of the regulation 28 report remain.

For completeness, the CQC National Investigations team have also been looking into the death of Rose Hollingworth specifically, this investigation is ongoing, and the outcome will be shared with the coroner separately, once complete.

Yours sincerely

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Deputy Director of Operations- London and East of England Network