Care Quality Commission
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Telephone: [redacted]

www.cqc.org.uk

Kally Cheema LLB
HM Senior Coroner
[redacted]
Cc: Dr Nicholas Shaw

31 October 2024

Our Reference: [redacted]
Your Reference: [redacted]

Dear HM Senior Coroner Kally Cheema and Assistant Coroner Dr Nicholas Shaw,

Regulation 28 Prevention of Future Deaths Report following Inquest into the death of James Reginald CAPSTICK.

Thank you for sending Care Quality Commission (CQC) a copy of the prevention of future deaths report issued following the sad death of James Reginald Capstick.

We note the legal requirement upon CQC to respond to the report within 56 days, that being by 27 September 2024, and would like to thank you for agreeing to our request for an extension until 04 November 2024.

We are grateful for the details provided in your report and confirmation of the outcome following inquest.

With regards your query in relation to CQC making further enquiries, we have taken action as outlined below.

CQC were informed of the outcome of the local authority safeguarding investigation into the use of CPR on 1 December 2021 including actions to be taken to prevent further incidents. Actions included internal investigation by the provider, audit of the incident, a refresher of basic life support training for all staff, and a referral to the NMC regarding the individual nurse's conduct. CQC followed up these actions and were reassured that staff had received refresher training in basic life support and that the provider had taken appropriate actions in relation to the registered nurse involved in the incident.

On 30 September 2022 CQC were notified of an allegation of abuse made by ambulance staff relating to concerns of neglect in relation to Mr Capstick whilst a resident at Westmorland Court Residential and Nursing Home. The concerns were identified by ambulance staff on 13 September 2022 when called to transport Mr Capstick to hospital. CQC are in the process of reviewing information related to this

safeguarding alert and are undertaking further enquiries to assess whether any further regulatory activity should be considered.

Following receipt of notification of the death of Mr Capstick a targeted inspection was carried out on 13 October 2022. This provided assurance regarding the safety of other service users at the location.

We have given careful consideration to the concerns raised in relation to whether it should be a requirement for care homes to have a defibrillator however this falls outside of the role and remit of CQC. We should clarify that the role and remit of CQC does not extend to prescribing how providers must meet the regulations stipulated, we place the onus and responsibility on providers themselves to make decisions around how best to deliver care safely and assure us of the same. There is no legal requirement for care homes to install equipment such as defibrillators but if they were to do so then there would be an expectation that staff are appropriately trained in how to use such equipment safely. Where equipment such as defibrillators are not installed, we would expect a provider to be able to demonstrate that they have suitable policies and procedures in place to ensure appropriate resuscitation methods can be carried out if required by suitably trained staff.

We hope this response provides sufficient information on the matters raised. Should you require any further information from CQC then please do not hesitate to contact us.

Yours sincerely

[redacted]

Interim Operations Manager