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By email to: [redacted], PA to HM Coroner for Surrey
([redacted])

Ms Susan Ridge, HM Assistant Coroner for Surrey
HM Coroner's Court
Station Approach
Woking
Surrey GU22 7AP
[redacted]

17 December 2024

Care Quality Commission
Our Reference: [redacted]

Dear Coroner Ridge,

Prevention of future death report (PFD) following an inquest into the death of Paul Rodney Batchelor

Thank you for granting an extension to enable the Care Quality Commission (CQC) to respond to your report issued in regard to Mr Batchelor's death at the Red House Care Home in Ashtead, Surrey. We offer our sincere condolences to the family of Mr Batchelor on their loss.

The report outlined two matters of concern; the first of which was addressed to the CQC and Medicines and Healthcare Products Regulatory Agency (MHRA) and the second to The Red House (Ashtead) Limited. We would like to take the opportunity to provide relevant background information before responding to your matters of concern.

Background: the role of the CQC

The CQC was established on 1 April 2009 by the Health and Social Care Act 2008 ('the Act'). The CQC is the independent regulator of healthcare, adult social care, hospital and community trusts and primary care services in England. The CQC also protects the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

The Act introduced a single registration system which applied to both healthcare and adult social services. Once registered with the CQC, providers such as The Red House (Ashtead) Limited were required to comply with conditions placed on their registration, as well as the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ('Regulated Activities Regulations 2010') and the Care Quality CQC (Registration) Regulations 2009 ('the Regulations').

The Regulations set out the essential standards of quality and safety that service users had a right to expect. The Regulated Activities Regulations 2010 were replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into effect from 1 April 2015. The Act requires the CQC to publish guidance about compliance with the requirements of the Regulations.

Background: deaths and serious incidents reported to the CQC

The Act also requires providers to notify the CQC of certain events such as serious injury or the death of a service user. When this happens, we obtain information from the provider and other sources to help us determine if there is an on-going risk of harm to others and whether the information suggests there was a breach of the regulations. Important questions we must consider include whether there has been a failure on the part of a registered provider to provide safe care and treatment resulting in harm or a significant risk of exposure to avoidable harm.

Harm caused through acts or omissions by an individual are referred to the appropriate authority, such as the police. Our statutory powers do not allow us to impose or implement corrective measures directly onto a provider. We do, however, expect the provider to respond quickly and comprehensively to any incident to manage risk and provide safe care. We also expect any changes made to be imbedded into their usual practice and sustained.

CQC Enforcement Powers

1. If we find that a registered provider or registered manager is in breach of provisions within the Regulations or the Act, we can take action to make sure that they improve. The action we take should be proportionate to the impact that the breach has on the people who use the service, how serious it is and whether we can allow the provider time to meet the Regulations. Unless we are seeking to close a service, we aim always to follow up any enforcement action with another inspection to ensure that improvement has been made. If we find continued breaches of regulations, we may escalate our enforcement response. However, we always consider each case on its own merit.
2. We take enforcement action where there is a serious breach resulting in risk for people and where we cannot leave the registered provider to decide on the timescale for meeting the Regulations. Enforcement action can be undertaken using either our civil or criminal powers. Our civil enforcement powers include:

    a) Issuing a warning notice;

b) Impose, vary, restrict or remove a condition from the provider's registration;

c) Suspend registration; or

d) Cancel registration.

Where people are at immediate risk of significant harm, and we cannot be assured that unless we act people will come to serious harm we can use our 'urgent' powers. This means that in some cases we are able to take immediate action to suspend or cancel registration or impose, vary, restrict or remove a condition from the provider's registration.

Background: the provider and brief chronology

Red House Care Home in Ashtead, Surrey, is a home with nursing for up to 26 people. The provider is registered for the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The location was inspected in 2014, 2016 and 2019. At the last full inspection in 2019 the location was rated as outstanding. We conducted a further inspection focussed on infection prevention and control (IPC) in 2022. Focussed inspections are unrated but in this instance we were assured that the provider was managing and mitigating IPC risks.

We learned from the provider of this tragic incident on 28 June 2023. Mr Batchelor died on 27th June having been admitted to the home on 26 May 2023. Following our serious incident protocol we gathered information from the provider about the circumstances of the death, their immediate actions and what measures they took to prevent further occurrence. Our initial contact with the provider commenced on 29 June 2023 and we were informed by them of the cause of death on 9 October 2023.

First matter of concern

"There may be a lack of awareness of the need to ensure adequate support for the mattress extension or bolster when using nursing care beds with an extension frame fitted. And that without adequate support there is a risk of death in that the mattress extension can fall through the bed frame creating a sufficient gap for a person to become wedged or stuck.

The lack of awareness of the risk may be compounded because when the mattress extension is fitted into the gap between the standard mattress and the footboard it may appear as though the bolster is adequately supported. Further that over time and use mattress deck extensions or other supporting framework can become detached or lost from the bed. Since this incident the court heard evidence that the care home and its sister care home have checked all existing extended profile beds and taken steps to ensure that they are fitted with the correct support.

However, the coroner is concerned that users of nursing care beds with extensions may need to be made aware of the circumstances of this death to prevent other deaths in similar circumstances".

Last year CQC contributed to a MHRA national patient safety alert (NPSA) on beds and bedrails and their guidance on safe use of bedrails. CQC promoted both publications through our provider bulletins in September 2023. These bulletins are sent to health and social care organisations registered with the CQC and are addressed for action by the registered manager or a senior manager identified to the commission beforehand (called the 'nominated individual'). The CQC already signposted providers to the MHRA bedrails guidance on our website page 'Regulations for service providers and managers: related guidance'

The MHRA guidance does not specifically address the risks of the device used in Mr Batchelor's case. However, the NPSA, in conjunction with the MHRA guidance on medical devices and their medical device checklist are intended to support providers to understand risk areas more broadly concerning beds and associated equipment, the importance of correct use (in line with any manufacturer's instructions), appropriate maintenance and training in their use.

As a result of this tragic event, CQC regulatory leadership and policy teams arranged for the specific NPSA to be highlighted as an example on our page: National Patient Safety Alerts in adult social care.

We have highlighted the MHRA NPSA on beds and bedrails; their guidance on bedrails, their medical device guidance and their medical device checklist in our November 2024 provider bulletin. The medical device checklist lists profiling or adjustable beds and we have made this link clearer for providers.

We have also included the MHRA medical device guidance and accompanying medical device checklist on our website page 'Regulations for service providers and managers: related guidance', which is shown in the link above.

In addition, our policy and regulatory leadership teams will be including references to the NPSA and relevant MHRA guidance into our new assessment framework, although we are currently developing our approach to this.

The NPSA itself was directed to care homes (among other organisations) and included requirements for adequate training on these devices, as well as requirements for regular servicing and maintenance.

Based on subsequent discussion with the MHRA, CQC learned that the instructions for use for the bed included clear diagrams on how to extend the bed correctly and the instructions for use also specified the requirements for regular servicing, carried out by an appropriately trained person.

This should have picked up the issue of the missing deck and the circumstances of how this happened in this case and what remedial actions have been undertaken since have been addressed with the provider by the CQC.

Second matter of concern

"The coroner notes that the care home has taken steps to ensure that any resident in distress and calling for help at night is heard. However, though the coroner has been shown minutes of briefings to care home staff conducted after Mr Batchelor's death emphasising the need to conduct checks of residents by going into a resident's room, she remains concerned that such briefings have not been formalised into care home policy and procedures. Nor do the minutes of those briefings explain what staff should do if they are frightened or concerned about entering a room on their own. There is the risk that rather than disturb a resident care home staff through, for example, fear or lack of time do not check a resident who may be in distress."

Since receipt of your report, we contacted The Red House (Ashtead) Limited to obtain evidence to help us determine the results of any additional action they intend to take in response to the prevention of future death report.

We received 56 submissions from the provider, including records relating to additional staff training in respect of managing challenging behaviour; modified policy, training and competency records as well as other interventions such as the implementation of 'QR codes' placed in residents' bedrooms so that staff, when completing night checks, need to enter the bedroom to scan the code on a handheld electronic device to record the check on the care monitoring system. The home management team explained they were investigating options for acoustic monitoring to be installed. We were informed that, as stated at the hearing, the staff member involved in the incident was no longer working at the care home.

Having reviewed the material the provider submitted, our view is that the changes made by the provider have now been established.

From a regulatory standpoint, there is always the risk that remedial plans put in place after an event of this nature might not stay embedded into normal practice or sustained. Therefore we will continue to monitor and assess the care home utilising information obtained from our insight data as well as other stakeholders such as the local authority. We do not exclude other assessment methodologies such as unannounced inspection visits, but for obvious reasons we would not wish to disclose details or intentions publicly.

In conclusion, we will continue to work with our MHRA colleagues in relation to any other notifications of incidents occurring in the care sector involving harm to service users through entrapments in beds and associated devices. We will take robust action as necessary.

Should you have any further questions, please do not hesitate to contact me.

Yours sincerely,

[redacted]

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Deputy Director
South Network Team 3