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HM Senior Coroner: Professor Paul Marks BA LLM MD FRCS

The Coroners Courts & Office
The Guildhall
Alfred Gelder Street
Kingston upon Hull
HU1 2AA

By Email [redacted]

11 December 2024

Care Quality Commission
Our Reference: [redacted]

Dear HM Coroner Professor Paul Marks,

CQC response to prevention of future death report [Name of Deceased]

Thank you for naming the Care Quality Commission (CQC) as a respondent in the prevention of future death report issued on 5 November 2024 following the death of Janet Brown.

Background

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 is where people using services have sustained avoidable harm including death, have been exposed to a significant risk of avoidable harm, or have suffered a loss of money or property as a result of a failure by the Registered Person. The 'Registered Person' 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.

Criminal enforcement can arise from single specific incidents where the incident and resulting harm provides evidence of a serious breach of a prosecutable regulation by the Registered Provider.

We have reviewed all our records and cannot find that we received a statutory notification in relation to Janet Brown's death. Failure to provide statutory notifications in accordance with Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 is a criminal offence and we have contacted the service to about this. The provider has advised us that the death did not occur while services were being provided in the carrying on of a regulated activity and no further regulated activity was completed following the admission to hospital. We have requested Janet Brown's care records so this can be reviewed, and so that we can consider whether any other regulatory action needs to be taken.

Regulatory History

Bridlington was registered with CQC on 7 February 2019 under the current provider, A & B Healthcare Limited. In that time, the location has been inspected twice; once in January 2020 (Appendix 1) and once April 2023 (Appendix 2). On both occasions, the location was rated Good in all the domains assessed. In the time since CQC last inspected Bridlington, ongoing monitoring of the service had not identified any emerging risk.

We note that the concerns are as follows:

1. **Carers at times spent no more than 15 minutes, on one occasion 8 minutes, with Ms Townend. Bearing in times the tasks, document keeping and care to administer and considering Early Warning Signs have there was no attention to detail; Their duties when there included to prepare meals, conduct personal care if required and talk to the service user. 8 to 15 minutes is not an adequate time to conduct these tasks;**

   Both inspections of Bridlington found no concerns regarding the deployment of staff and the published reports include positive feedback from people about the support they received. In response to the concerns raised by the coroner concerning the death of Janet Brown, the CQC has received an action plan from the provider addressing the duration of staff visits. We intend to undertake an unannounced assessment of the service which will include staff having adequate time to meet people's needs. CQC only regulates the carrying out of personal care, however, adequate

time must be afforded to staff to support people in a safe, person-centred way (Appendix 1, Appendix 2).

2. **Carers did not escalate any concerns when Ms Townend was not eating. As Ms Townend had comorbidities and was at risk of infection nutrition was very important;**

   The inspection of Bridlington in January 2020 found no concerns regarding the support people received to eat and drink and/or the ongoing assessment and monitoring of people's needs and support to access other healthcare services. The inspection of Bridlington in April 2023 did not include these areas. In response to the concerns raised by the coroner concerning the death of Janet Brown, the CQC has received an action plan from the provider addressing nutrition and hydration. We intend to undertake an unannounced assessment of the service which will include nutrition and hydration and how staff identify people's changing needs and escalate concerns. (Appendix 1, Appendix 2).

3. **Carers did not escalate any concerns when Ms Townend was unwell with sickness. There were a number of times Ms Townend presented with having been sick and this was not considered as a concern;**

   Neither inspection of Bridlington raised concerns about staff not escalating concerns about people. The inspection of Bridlington in January 2020 found staff supported people to access health care professionals and referrals were made when required. (Appendix 1). In response to the concerns raised by the coroner concerning the death of Janet Brown, the CQC has received an action plan from the provider addressing how staff will monitor people's health and well-being. We intend to undertake an unannounced assessment of the service which will include how people are supported to live healthier lives and how the provider will monitor peoples care (Appendix 1, Appendix 2).

4. **Carers did not accurately record concerns regarding Early Warning Signs (EWS) or escalate when they were present. The EWS were always recorded as no concerns. This was not correct as there were occasions where Ms Townend was displaying signs that were Early Warning Signs which should have been escalated;**

   Neither inspection of Bridlington raised concerns about the accuracy of record keeping. In both cases, our inspections found checks and audits were in place to ensure good governance of the service. (Appendix 1, Appendix 2). In response to the concerns raised by the coroner concerning the death of Janet Brown, the CQC has received an action plan from the provider addressing staff training, oversight of records and processes for escalating concerns. We intend to undertake an

unannounced assessment of the service which will include recording keeping, governance processes and oversight of people's care.

5. **Carers did not follow up with Ms Townend when she had indicated she was seeking GP support as she was feeling unwell. This was recorded in the Observation Log that Ms Townend said she would contact her GP however the proceeding carers did not enquire whether this had been done;**

   The inspection of Bridlington in January 2020 found no concerns regarding how staff supported people to access healthcare services and support (Appendix 1). In response to the concerns raised by the coroner concerning the death of Janet Brown, the CQC has received an action plan from the provider addressing their systems for monitoring people's health effectively within the staff team. We intend to undertake an unannounced assessment of the service which will include governance processes and oversight of people's care.

6. **Although Ms Townend was deemed to have capacity carers did not escalate any concerns when Ms Townend was making unwise decisions to refuse personal care, decline food and decline medical intervention. This meant that she was sitting at times in her own faeces and becoming weak and it was not considered whether she needed to be reassessed regarding her capacity.**

   Neither inspection of Bridlington identified concerns regarding staffs ability to recognise and escalate safeguarding concerns. The inspection of Bridlington in January 2020 found staff had a good understanding of safeguarding processes (Appendix 1). In response to the concerns raised by the coroner concerning the death of Janet Brown, the CQC has received an action plan from the provider addressing staff understanding of the mental capacity act. We intend to undertake an unannounced assessment of the service which will include safeguarding and decision making. We have also requested immediate assurances from the provider regarding their safeguarding processes.

Yours sincerely

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[redacted]

Deputy Director,