Care Quality Commission
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Mr Andrew Harris
Assistant Coroner
HM Coroner for London Inner South Coroners Court
1 Tennis Street
London
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06 May 2025

Dear Mr Harris,

Care Quality Commission:
Response to Regulation 28 Report to Prevent Future Deaths following the inquest into the death of Mr Paul Timothy Dunne.

Thank you for your Regulation 28 Report to Prevent Future Deaths dated 18 February 2022 about Mr Paul Dunne's death. I am replying on behalf of the Care Quality Commission.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Dunne's death, and I offer my sincere condolences to his family and loved ones. Your report's circumstances are concerning, and I am grateful to you for raising these matters.

In the Regulation 28 Report to Prevent Future Deaths, the following concerns were raised to the CQC:

1. Individual mental health professionals appeared to have gaps in knowledge and judgment. The director, who was spokesperson for the Mental Health Trust, did not seem to appreciate the seriousness of these deficits.

- A mental health liaison nurse, who now is alarmingly manager of these nurses, did not recognise the patient as high risk, despite his having been persuaded to attend A&E by the police against his will, having just expressed suicidal ideation, made a previous attempt, with alcohol intoxication and absconsion, as at the time he denied suicidality. Even in retrospect, in court, she did not acknowledge her misjudgement. She also asserted incorrectly that a patient who has mental capacity cannot be assessed under the Mental Health Act.
- A mental health nurse of 9 years standing in the Home Treatment Team who acknowledged the risk to the patient's life could hardly be higher, failed to

document his assessment, as he could not find anywhere to write it before going on his break. No staff acknowledged that he had informed them of the risk. He assumed the patient would get 1:1 monitoring, but did not direct anyone to the need. When asked what he would have done if he had known there were no staff to conduct 1:1 monitoring, he rather lamely said that he could perhaps hang around for a bit longer.

2. The Mental Health Trust.

- Staff and it appears the director, even at the time of the inquest, did not appreciate that the A&E policies (Missing Persons, Shared Care) which required risk assessment after an absconsion and alerting managers to the need for extra temporary staff if 1:1 monitoring was needed, also applied to MH staff.
- Evidence was heard that staff in KCH A&E and Oxleas NH Trust had been trained on different risk assessment documents. Although meetings had been reinstated between departments, there had been no audit of absconsions or MH liaison in A&E.

In response to the individual points raised:

1. We recognise the distress and concern these events have caused and acknowledge the importance of accountability where there are apparent shortfalls in professional conduct or decision-making. However, it is important to clarify that the Care Quality Commission's regulatory remit, as established under the Health and Social Care Act (2008) and the associated Regulated Activities Regulations (2014), is focused on assessing and holding providers rather than individual staff accountable for meeting fundamental standards of care. While we do not have the authority to investigate or act against individual healthcare professionals, we expect providers to ensure that their staff are competent, appropriately trained, and supported to deliver safe and effective care. Where there are indications that individual knowledge gaps or lapses in professional judgment reflect broader systemic or cultural issues within a provider, such as inadequate supervision and training, poor risk management protocols, or ineffective governance, we may examine these as part of our regulatory activity.

   Concerns such as those described contribute to our ongoing monitoring of the provider's performance. Where patterns might suggest systemic failings, we carry out further monitoring, engagement and assessment activities and/or require the provider to take specific actions to address risk and improve quality.

2. Our regulatory focus is on the systems and governance arrangements providers have to deliver safe, effective, and coordinated care. Concerns regarding the apparent misunderstanding or inconsistent application of key policies, such as those related to missing persons or staffing for 1:1 monitoring, fall within this remit when they indicate potential provider-level failings. In particular, any indication that staff and senior leaders, including directors, did not recognise the applicability of trust-wide risk and safety policies is a matter of concern. We expect all providers to ensure that relevant policies are clearly communicated, understood by staff, and implemented consistently across services and that staff from different NHS trusts are supported to work together and understand how their policies and procedures support joint working to deliver safe and effective care. This includes ensuring that staff working in shared care environments, such as mental health liaison teams in acute settings, operate under a coherent

and aligned set of standards. We also note your concerns about using different risk assessment tools by staff from different trusts (King's College Hospital NHS Foundation Trust and Oxleas NHS Foundation Trust) and the lack of audit or oversight of absconsions or mental health liaison activities.

We will take these concerns into account as part of our ongoing monitoring of the providers. We may consider them alongside other intelligence to assess whether further regulatory action is warranted through monitoring, engagement and assessment activities. Where there is evidence of systemic risk or breaches of the fundamental standards of care, CQC may take steps including assessments and enforcement action, or require provider improvement plans.

Currently, information shared from members of the public, providers, system partners and stakeholders feeds into our provider monitoring system. The Care Quality Commission local integrated assessment and inspection teams are monitoring and engaging with Oxleas NHS Foundation trust and King's College Hospital NHS Foundation trust through continuous monitoring, regular engagement, and risk-based assessments. We gather intelligence from various sources, including patient and service user feedback, notifications, incident reports, and information from partner organisations, to assess the quality and safety of care. Regular engagement meetings with trusts provide opportunities to review performance, discuss concerns, and seek assurance on improvements. We also attend relevant committee meetings such as Oxleas NHS Foundation trust's mortality surveillance committee, where the trust reviews patient and service user deaths to improve patient safety and learning from incidents.

Internally, at the CQC, we will incorporate any proposed trust actions and information from incidents, notifications, and Regulation 28 Prevent Future Deaths reports into our ongoing monitoring with the service and any subsequent engagement work or assessment planning. We will ask Oxleas NHS Foundation trust for the action they intend to take because of this Prevent Future Deaths Report and monitor those actions as part of our ongoing monitoring and engagement with them. Information such as this will be reviewed via our internal Specific Incidents Guidance (SIG), which requires and identifies the process for the initial assessment of information relating to specific incidents of potential avoidable harm based on the details of the incident. The SIG guidance refers to Regulation 28 Prevent Future Deaths reports and other correspondence from providers and system stakeholders, such as coroners, as being capable of amounting to information requiring an initial assessment under the SIG process. Inspectors supported by operations managers assess if the incident gives rise to potential further monitoring, assessment and/or enforcement functions as appropriate and if the incident suggests the harm sustained was avoidable, may have resulted from a breach of a prosecutable fundamental standard and was the result of the registered person.

Where the information, such as a PFD report, triggering the initial assessment, does not provide sufficient evidence to inform a reliable answer to these questions under SIG, we may undertake further enquiries. When risks are identified, the CQC may carry out targeted or unannounced assessments and, if necessary, take regulatory action such as issuing requirement notices or enforcement measures to ensure the trust meets fundamental standards of care and drives improvement.

We are grateful for the information you have shared. It is invaluable in helping us monitor the quality of care provided across services and to ensure that providers are meeting the standards expected under the Health and Social Care Act (2008) and the associated Regulated Activities Regulations (2014). We appreciate the coroner raising these concerns with us. We will continue to monitor the trusts and any information we receive in line with our internal processes and methodology. If you have any further queries, please do not hesitate to contact us further.

Yours sincerely,

Deputy Director of Operations