Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
[redacted]
www.cqc.org.uk

Mr Crispin Oliver, Assistant Coroner
West Yorkshire Western Coroner Area
H.M. Coroner's Court
Cater Building
1 Cater Street
Bradford
BD1 5AS

[redacted]

19th September 2025

Dear HM Coroner,

Prevention of future death report following inquest into the death of Myles Edward Scriven ([redacted]

Thank you for sending the Care Quality Commission (CQC) a copy of the Regulation 28: Report to Prevent Future Deaths, which was issued following the death of Myles Edward Scriven, in which CQC was named as a respondent.

Firstly, we would like to extend our condolences and sympathies to Myles' family and friends.

CQC has a process to follow whenever a Regulation 28 report is received, including where CQC is named within the report.

In line with CQC's enforcement and internal specific incident guidance, policies and procedures, a Decision Review Meeting (DRM) has taken place. This initial assessment enables CQC to consider and determine any appropriate regulatory response. This can include monitoring, inspection and/or civil enforcement action to protect service users from ongoing risks; and to assess and determine whether there may be reasonable grounds to suspect that a service user may have sustained avoidable harm or been exposed to a significant risk of avoidable harm, as a result of registered person failure to provide safe care and treatment.

Specifically in relation to Calderdale and Huddersfield NHS Foundation Trust, the local CQC operational team have held an initial DRM where relevant information from stakeholders and internally held information within CQC is shared and a course of action is decided on. Following this we have contacted the Trust to inform them we have received the Regulation 28 report, and they are sending us further

information about the full circumstances surrounding this sad case and the actions they have taken, or are planning to take, to prevent reoccurrence.

Calderdale and Huddersfield NHS Foundation Trust were last inspected in June 2018 at a well led level, when it was rated as good overall and for all key lines of enquiry. However, given your report into the death of Myles Scriven, and the length of time since we last inspected, we are considering our regulatory response following the initial DRM which **may** include carrying out an inspection. Please note this is confidential at this stage. The DRM particularly focused on concerns in relation to those outlined in your report including:

- The impact of mental capacity assessments auditing, the nursing leadership walkaround of all wards auditing that LD and autism policies are applied in practise.
- How the outcomes of any audits were acted on
- Taking into consideration that much of the above which is now in place was already in place in 2022. But in Myles's case it had no impact
- Specialist staff recommendations were not followed up
- The culture throughout the staff was not reflective of the specialist's advice

In response to the known challenges faced by people with a learning disability and autistic people when they access health care services, as well as feedback from people with lived experience, CQC had already begun a program of work focusing on the health inequalities faced by this population group. This includes taking action to review how we consider whether Trusts are providing safe care and treatment for people with a learning disability and autistic people. Specifically, we are reviewing and will update the guidance that we provide for our inspection teams to follow. This aims to prompt inspectors to carry out a more thorough assessment than currently takes place and gives them the necessary tools to do so. Our regulatory leadership teams are leading on this. Additional areas of work in this specific area focus on how CQC can work more closely with the Learning from Lives and Deaths -People with a learning disability and autistic people program (LeDeR) – sharing information and building closer links in order to do so more effectively.

We are also taking steps to ensure our inspection teams have the right support and training to review how Trusts provide care and treatment for people with a learning disability.

We are arranging some bespoke upskilling sessions for our secondary care inspection teams. This will cover pertinent issues including what people with lived experience have told us about issues they have faced when accessing hospital care. Further, it will support inspection teams to consider, understand and analyse how services are meeting the needs of their population.

Since the 1st July 2022, all CQC registered health and social care providers have been required by the Health and Care Act 2022 to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people with a learning disability. This should be at a level appropriate to their role.

On the 19th June 2025, the Oliver McGowan Code of Practice was published and laid before parliament by the Department of Health and Social Care. The code commenced on 6th September 2025 and is now legal guidance. The purpose of the code is to explain what is meant by training that is ‘appropriate to the person’s role’ and to provide guidance on how to ensure all staff receive such training.

Compliance with the standards set out in the code of practice, is expected to ensure that every person receives high quality learning disability and autism training that meets their learning needs and is appropriate to their role. Importantly, this aims to improve the experiences and outcomes of autistic people and people with a learning disability when they access CQC regulated health and social care services. This means that CQC registered providers must ensure that they provide each member of staff with training that meets the standards set out in the Code in order to deliver the best possible outcomes. CQC will use the Oliver McGowan Code of Practice when considering whether providers are meeting the requirements of the regulation.

Throughout September, the CQC’s autistic people and people with a learning disability team will be running bespoke upskilling sessions on the mandatory training requirement and code of practice with the aim of equipping inspection teams with the knowledge and skills they need to regulate this requirement effectively and consistently. Specifically pertinent to the case of Myles Scriven, the code of practice enables both providers and CQC to consider the extent to which learning is put into practice.

I hope this response addresses your concerns and clarifies the role and remit of CQC in relation to this matter. If you have any further concerns or queries, please contact us via email [redacted].

Yours sincerely

[redacted]

[redacted]
Operations Manager
West Yorkshire, Network North.