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]

17 September 2025

Dear Mr Oliver,

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 loved ones.

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

In line with CQC's enforcement and internal specific incident guidance, policies and procedures, a decision review meeting (DRM) takes place. This initial meeting involves an assessment which enables CQC to consider and determine any appropriate regulatory response. This may include monitoring of relevant regulated services, carrying out an inspection and/or taking civil enforcement action to protect service users from ongoing risks. In addition, we 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 Dalton Surgery, the local CQC team held an initial DRM. Following this they have been in contact with the GP practice to establish the full circumstances surrounding this sad case and to request information about the action they also intend to take to prevent reoccurrence. They have received the information, including an action plan stating the improvements the practice intends to

make to prevent future deaths and improve how they deliver care and treatment for patients with a learning disability and autistic people.

Dalton Surgery has been inspected once previously, in October 2016, when it was rated as good overall and for all key lines of enquiry. At the time of that inspection, we specifically reviewed how the service managed the care and treatment of specific population groups, this included 'people whose circumstances may make them vulnerable'. The inspection report reflected that we were satisfied with the care provided by the practice at that time. This included ensuring that systems were in place to share information with other health care professionals to enable them to deliver safe care and treatment. However, given your report into the death of Myles Scriven, and the length of time since we last inspected the practice, a decision was taken at the DRM to carry out an inspection and we are now in the process of planning a full comprehensive assessment.

In response to the known challenges faced by people with a learning disability and autistic people when they access primary 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 a GP practice is providing safe care and treatment for people with a learning disability and autistic people. Specifically, we are reviewing and will update the guidance in respect of this, 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 give 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 LeDeR program – 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 GP practices provide care and treatment for people with a learning disability and autistic people.

We are arranging some bespoke upskilling sessions for our primary care inspection teams. This will cover pertinent issues including what people with lived experience have told us about issues they have faced when accessing primary 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 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 relevant regulations.

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]
Deputy Director – West Yorkshire, South Lancashire and Cumbria
[redacted]