HM Senior Coroner
The Coroners Courts & Office
The Myle Cross Centre
92 Macaulay Drive
Lincoln
LN2 4EL

[redacted]

15 October 2025

Dear HM Senior Coroner (Mr Paul D Smith)

Regulation 28 Report following the inquest into the death of Mrs Dye

[redacted]

We are sorry to hear about the death of Mrs Dye and we offer our sincere condolences to her family.

Care Quality Commission (CQC) first became aware of the death of Mrs Dye on receipt of the Regulation 28 Report to Prevent Future Deaths (the Report) on 25 July 2025. We understand the death occurred whilst Mrs Dye was receiving surgery at Scunthorpe General Hospital, which is a location of Northern Lincolnshire and Goole NHS Foundation Trust (the Trust), which is a CQC Registered Provider.

CQC are named responders in the Report. We are grateful for the extension of time granted for our response to be provided, that being until 16 October 2025.

In the Regulation 28 Preventing Future Deaths report the HM Coroner raised the following concerns:

- Review of the guidance
- Review of the need for any consequential training.

Having considered the report and additional documentation provided, we understand the matters of concern to be as follows:

- There is no current guidance in relation to the siting of Emergency Power Off (EPO) restart buttons remote from an affected room; review of such guidance is invited
- Further, review of the need for any consequential training is also invited

It is important to highlight from the outset that CQC does not have the power to set guidelines or training expectations, rather we assess a registered provider's ability to meet regulatory requirements. Whilst assessing regulatory compliance can involve the application of relevant guidelines, it is not within the scope of CQC's regulatory powers to set the guidelines or any associated training requirements.

Whilst CQC are unable to provide further response in respect of whether specific guidance or training requirements should be implemented, we can set out what actions have been taken following receipt of the Report and our engagement with the Trust in this matter.

CQC last undertook a comprehensive inspection of the Trust in June and July 2022.

The CQC report was published in December 2022, and we rated the Trust as "Requires Improvement." A copy of the report can be found on our website - Trust - RJL Northern Lincolnshire and Goole NHS Foundation Trust (02/12/2022) INS2-12039916291

Following receipt of the Report, CQC engaged with the Trust and requested evidence of any action they had taken to date following the tragic death of Mrs Dye. The Trust responded by stating that at the time of the incident, the police had assumed primacy over the investigation and had later concluded that there was no criminality. The Trust have provided us with a copy of external independent reports completed in September 2020 and February 2024 on behalf of the police. The reports concluded that the treatment room power interruption was due to an unknown electrical fault, with no fault on the part of the Trust, its systems, or staff.

At the time of the incident the Trust logged it as a serious incident on the Strategic Executive Information System (StEIS). However, this was later de-logged with agreement from the clinical commissioning group (CCG). This meant the Trust did not complete a serious incident investigation report.

Subsequent external independent inspection reports were recommended by the Medicines and Healthcare products Regulatory Agency (MHRA). The reports from September 2020 and February 2024 concluded the fault was a rare event caused by an electrical fire within the EPO control room.

The Trust has confirmed the following recommendations from this report and inquest have been actioned:

- The EPO's at Scunthorpe and Grimsby hospitals now have durable labels (x-ray system emergency power off) and photos were provided as evidence to the coroner

- The Trust has an Electrical Safety Group which meets on a quarterly basis as recommended by the Health Technical Memoranda HTM 06-01

- The Trust has confirmed the installation reports have been completed in accordance with the relevant guidelines

In relation to the installation of remote on/off buttons with integral lamps the Trust discussed this at a governance meeting in April 2025. They also added that there is no current guidance requiring this, which was also highlighted by the independent engineer.

CQC will continue to monitor the Trust as part of our regulatory activity.

We hope that our response addresses your concerns in so far as we are able to. If we can provide any further information, then please do not hesitate to contact us.

Yours sincerely

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Deputy Director of Operations
Network North