Care Quality Commission
Citygate
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www.cqc.org.uk

Mr Hassan Shah, Assistant Coroner

28 May 2026

Care Quality Commission

Dear HM Coroner Mr Hassan Shah

Prevention of future death report following inquest into the death of Mr John Hay

Thank you for sending the Care Quality Commission (CQC) a copy of the prevention of future death report issued following the death of Mr John Hay.

CQC has contacted The Care Bureau Limited to request written confirmation and evidence of the action they have taken to date following this death and any additional action they intend to take in response to the prevention of future death report.

We note the legal requirement upon The Care Bureau Limited to respond to your report within 56 days.

I would firstly like to express my deepest condolences to Mr Hay's family for their loss.

I note your Regulation 28 report was addressed to The Care Bureau Limited and West Northamptonshire Council as well as to CQC; this response is prepared solely on behalf of the CQC. It relates to the role of CQC as well as its assessment and inspection methodology for those organisations it regulates.

Regulatory history:

The Care Bureau Limited - Domiciliary Care – Northampton was last inspected 24 November 2022 and was rated Requires Improvement with a breach of Regulation in relation to the governance and oversight of the service. The provider submitted an action plan to CQC 15 March 2023 to set out how it intends to improve to address the breach of regulation identified in the last inspection. We continue to monitor the service through our ongoing monitoring processes.

Matters of concern

We acknowledge the Coroner's view that the matters of concern raised did not cause or contribute to Mr Hay's death, but they might in other cases.

1. **The Risk Assessment in the care plan is neither completed nor reviewed with nursing or medical input, but includes, amongst other things, actions to be taken when a person is on blood thinners. In the present case, the only scenario covered was in relation to a person who has "heavy bleeding". The obligation to complete the risk assessment and determine actions falls upon the care team, none of whom have any medical training, aside from basic first aid.**

We have reviewed evidence from The Care Bureau Limited showing that they have updated their anticoagulant and fall risk assessment template and that this is in place across all their services.

The Care Bureau Limited have themselves identified that although the care plan for Mr Hay identified the risk of falls and his anticoagulant risk, the Risk Management Plan treated these as separate risks. The Care Bureau Limited have acknowledged that their Care plan did not distinguish between witnessed and unwitnessed falls. They have recognised that for an unwitnessed fall it may be harder to assess whether there was any risk from potential head trauma.

We have reviewed evidence from The Care Bureau Limited that they are updating their electronic care records App, used by care staff, to ensure anticoagulant risk is appropriately highlighted to provide clearer guidance for care staff. The Care Bureau Limited have also stated to CQC that they are updating people's care plans to include a clearly signposted Emergency Action Plan to clarify the actions that care staff will take in certain emergency situations including calling 999 in the event of a witnessed fall.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care and treatment includes risk management and CQC's assessment framework includes a quality statement looking at how care providers work with people to understand and manage risks. We assess how care providers are meeting these requirements through our ongoing monitoring of services which includes reviewing information we receive from and about services. We also assess through our inspection activity.

CQC would expect to see care plans and risk management plans clearly identifying risks to people and the actions staff should take to mitigate those risks. We would expect care providers to ensure that staff understood people's care plans and risk management plans. This should be monitored through the provider's oversight and auditing systems. This is an area that we consider during our assessment and inspection activity in relation to Regulation 17: Good governance.

2. **The process/system for escalation to get medical input was unclear. In the current case, it was accepted with the benefit of hindsight that when a frail elderly person on blood thinners suffers a fall, a medical assessment should probably be done. However, after the morning visit, it was Mr Hay himself who made the decision (despite having suffered a fall and having a diagnosis of dementia) without input from his family. At the time of the evening visit, the care team contacted the son for a decision rather than simply assessing the situation and making a decision.**

We sought clarification from The Care Bureau Limited, who confirm that Mr Hay's assessment and care plan did not give detail in relation to any powers of attorney in place. Nor did it include the scope of any powers to make decisions in relation to medical treatment.

There is no clear rationale for why the care staff accepted Mr Hay's decision that he did not want to call for an ambulance after his unwitnessed fall on 26 September 2024 or whether any other medical assessment was considered. Mr Hay's care plan of 18 September 2024 stated that although he had a diagnosis of dementia this did not affect his capability to understand what others are communicating with him or his ability to answer questions. The decision about whether to seek emergency medical assessment was not a day-to-day decision. It would require careful consideration in relation to whether Mr Hay had the mental capacity to make this decision having had regard to the increased risks relating to the anticoagulants prescribed.

When Mr Hay was found on the floor during the afternoon call on 26 September 2024 again it is unclear why an ambulance is not called and staff again took the decision not to follow Mr Hay's care plan which stated "If Client falls carers must dial 999".

The care staff did notify the The Care Bureau Limited office staff. The office staff then notified Mr Hay's son, who they say who advised not to call an ambulance. It appears staff took this direction despite the lack of evidence in relation to any power of attorney or assurances that Mr Hay's son was aware of the risks associated with falling for people who are taking anticoagulants.

The Care Bureau Limited have acknowledged that there lacked detail in Mr Hay's care records of whether any power of attorney was in place. The Care Bureau Limited also recognise that further clarity was needed for people using the service and relatives regarding the action staff will take in the event of known risks such as falls.

The Care Bureau Limited have committed to reviewing their assessment documentation relating to powers of attorney before the end of May 2026. They are also reviewing and updating risk assessments, guidance in relation to falls and anticoagulant medicines. In addition, they are reviewing staff training in moving and handling which incorporates falls.

In addition to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13: Safeguarding service users from abuse and improper treatment

and Regulation 11: Need for consent, CQC's Assessment framework includes the quality statement Consent to Care and Treatment. This considers how care providers are meeting the requirements of The Mental Capacity Act 2025. Regulation 12: Safe care and treatment includes risk management in conjunction with a quality statement which focuses on how care providers work with people to understand and manage risks. We assess compliance with the quality statement and Regulations as part of our ongoing monitoring and assessments of registered care providers.

3. **The process/system by which missing or spent medication is actioned was unclear. In the current case, Mr Hay's son was responsible for ordering medication. However, the system by which the care team would notify him was unclear.**

CQC would expect to see this detail within people's care plans particularly where responsibility for the management of medicine is shared between care staff and the person or family members.

The Care Bureau Limited have provided evidence to CQC to show that they have issued a reminder to all field staff to request additional medication at least seven days before a service user's supply runs out. They are also updating care plans to reference this instruction which they state should be completed by the end of May.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care and treatment includes medicines management and additionally CQC's assessment framework includes a quality statement relating to Medicines optimisation. We assess compliance with this quality statement and Regulation as part of our ongoing monitoring and assessments.

If you require any further information or clarification please do not hesitate to contact CQC using the following contact details:

By email: [redacted]

By post: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please include the reference number [redacted]

Yours sincerely

Deputy Director of Adult Social Care