Care Quality Commission

North Region
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616172

www.cqc.org.uk

Mr S Nelson
HM Senior Coroner
Office of HM Coroner
The Phoenix Centre
L/Cpl Stephen Shaw MC Way
Heywood
OL10 1LR

20 March 2015

Our ref: [redacted]

Re: Anne Horner (deceased) Regulation 28 notice

Dear Mr Nelson

We were very sad to read about the death of Mrs Horner and the circumstances in which she died. Thank you for your report and the requirement for us to review what actions should be taken to try to prevent the occurrence or continuation of such circumstances in the future.

Please treat this letter as the formal response of the Care Quality Commission ('CQC') to your report dated 11 February 2015.

In terms of the actions that we have taken since theevent , we have been in dialogue with the provider requesting information relating to the incident. This has included requiring information from the provider under Section 64 of the Health and Social Care Act 2008. This information has now been provided. The provider has confirmed to us in writing that the toilet has been decommissioned and is no longer in use.

We note your comment relating to toilet doors opening outwards. It seems to us that it would not be appropriate for the CQC to provide any expert comment in this area. We respectfully suggest that it would be more appropriate for the Building Control department of the Bury Metropolitan Borough Council to advise on such matters. We are mindful on the one hand that a door opening outwards into a corridor might reduce the risk of a person using the toilet striking their head against an opened door while increasing accessibility in the event of a fall. On the other hand, we also recognise that outward-opening doors may pose inherent risks to passers-by outside a toilet and especially so where a service is frequented by people who may have a visual impairment or mobility problems. It is the responsibility of the service provider to manage the risks posed by whichever mechanism it implements to ensure the welfare and safety of service users.

In terms of further actions that we have undertaken to address concerns highlighted in your report, the CQC has also inspected the home on an unannounced basis. The resultant report is currently in draft format and will shortly to be sent to the provider for comment and any factual accuracy representations. We have identified a number of areas the provider needs to address within the care home although none relate to the concerns raised in your report. If you wish we will send a copy of the report to you once it has been published.

We hope that this letter adequately sets out the steps that the CQC has taken to address the concerns identified in your report following the inquest following into Mrs Horner's very sad death. If we can be any further assistance please do not hesitate to contact us.

Yours sincerely

[redacted]

[redacted]
Head of Inspection Adult Social Care (North Central)