HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: [redacted]
Fax: 03000 616171

HM Coroner Mr. David Ridley

11 March 2021

Care Quality Commission (CQC)
Our Reference: [redacted]

Dear HM Senior Coroner

Prevention of future deaths report following the Inquest into the death of Mary Grace Johnson and Ms. Vhari Ingall.

Thank you for your Regulation 28 report to prevent future deaths issued following the inquest into the sad death of Mary Grace Johnson and Vhari Ingall.

The role of the CQC
The role of the Care Quality Commission (CQC) as an independent regulator is to register health and adult social care service providers in England and to inspect whether or not the fundamental standards are being met. The legislation that governs this includes The Health and Social Care Act 2008 and associated regulations.

Prevention of Future Deaths Report
In the regulation 28 report, you have asked CQC to consider the following concern:

I would be grateful if you would please consider as part of your inspection methodology including looking at the system in place for the management of TEP/DNARs, as my concern is that with inaccurate information and the inability to check that information that potentially decisions could be made that perhaps would not be made leading to allowing somebody to die that was based on inaccurate information.

CQC do not always routinely check all TEP/DNAR records as part of an inspection. This will depend on the service; the type of inspection and what concerns have been raised from the public or other stakeholders.

All providers must comply with the regulations as set out in The Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. The regulations that would be considered with any reviews around DNAR/TEP forms would be:

- Regulation 9 (Person-Centred Care)
- Regulation 11 (Need for Consent)
- Regulation 12 (Safe Care and Treatment)
- Regulation 13 Safeguarding service users from abuse and improper treatment
- Regulation 17 (Good Governance)

For all health and social care providers, CQC would look at the regulations outlined above and determine whether there is evidence of compliance under each of the Key Lines of Enquiry (KLOE) relative to the provider type. This would include care planning, end of life care and treatment, consent processes and who was involved in the decisions around care planning and treatment.

A provider's compliance with the regulations will be assessed at inspection. As part of a CQC comprehensive inspection the practice will be inspected against five key questions, whether a service is safe, effective, caring, responsive and well led. Each of the five key questions are broken down into a further set of questions, the key lines of enquiry (KLOEs). When CQC inspects, these are used to help CQC decide what the inspection needs to focus on. For example, the inspection team may look at care planning, end of life care and treatment, consent processes and who was involved in the decisions around care planning and treatment. As part of the consideration as to whether a service is safe, effective, caring, responsive or well led, CQC will consider how governance systems, processes and practices keep people safe, how these are monitored and improved and whether staff receive effective training in safety systems, processes and practices.

In the event of a specific DNAR/TEP concern being raised by a whistle-blower, CQC inspection teams may conduct investigations to determine whether providers undertake appropriate DNAR/TEP assessments, how accurate and complete is the information is and how DNAR/TEP forms are reviewed. Checks are made to ensure providers processes and systems align with the Resuscitation Council's UK Publication: 'Decisions relating to cardiopulmonary resuscitation' and TEP forms in line with ReSpect guidance seen on the Resuscitation Councils website.

In October 2020, the Department of Health and Social Care asked CQC to review the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions during the COVID-19 pandemic. This has been an area of shared concern about the blanket application of DNACPR decisions. Our interim report was published in November 2020. A national report of our findings and recommendations will be published by March 2021. This report will set out all the themes and trends we have found, outlining any known changes to the use of DNACPR in response to the pandemic and describing good practice for the future.

We are currently now in a period of consultation about our next steps of regulation. During this time, we will continually keep our scope of regulation under review and

update our regulatory approaches frequently. This may include strengthening how we regulate care and treatment around end of life and specifically DNAR/TEP forms in the future.

We continue to respond to risk via routine monitoring and inspection during this consultation period, including concerns and issues raised in this report.

CQC Regulatory Action:

CQC undertook an inspection in June 2016 at the GP practice where Vhari Ingall was registered as a patient. This inspection was undertaken prior to the death of Ms Ingall. There were no areas of concern in relation to the relevant practice policies, staff understanding, training and systems to support patients with their care, treatment or planning for their end of life.

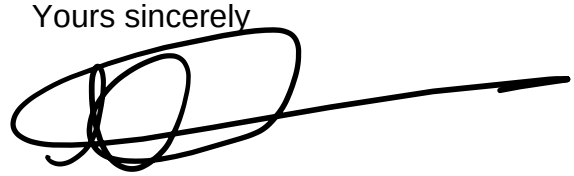
We undertook an annual regulatory review at the same practice in July 2019 and our assessment found no areas of concern in relation to the care and treatment of patients at this time.

In terms of Mary Grace Johnson, your concerns relate to the DNAR/TEP forms being used for people who choose to take their own life. We have reviewed the information and believe that there were no concerns about Ms Johnson's GP practice. Patford House Surgery was inspected in November 2018 and there were also no concerns relevant practice policies, staff understanding, training and systems to support patients with their care, treatment or planning for their end of life.

Where CQC identifies that regulations are not being met, we use our enforcement powers to require improvements to be made. We continue to do this and will share key learning and practice points from the inquest into the death of Vhari Ignall and Mary Grace Johnson with inspectors.

We hope that this response addresses your concerns. Should you require any further information then please do not hesitate to get in touch.

Yours sincerely



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Head of Inspection- PMS South East and South West.