HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

[redacted]

HM Area Coroner Emma Brown
Area Coroner for Birmingham and Solihull
50 Newton Street
Birmingham
B4 6NE

18 May 2021

Care Quality Commission (CQC)
Our Reference:

Dear HM Coroner

Prevention of future deaths report Ms Azra Hussain

Thank you for your Regulation 28, report to prevent future deaths issued following the inquest into the sad death of Azra Parveen Hussain also known as Azra Parveen Sultan. This response will address the role of CQC, summarise the inspection history of the service and address the specific issues you have raised in the report.

CQC's Role

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 function is The Health and Social Care Act 2008 and The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of CQC's regulatory role, inspectors assess whether or not a provider is meeting the needs of people in a safe way. Inspectors make judgements from their findings as to whether a service has mitigated the risks posed to people, for example, physical risks arising from existing health conditions and environmental risks based on the surroundings in which they live. The CQC's website signposts the provider and registered manager to relevant guidance on how they can meet our regulations and other related regulations, including approach to risk.

Ms. Hussain and Inspection History

Birmingham and Solihull Mental Health Foundation NHS Trust is registered with the Care Quality Commission for the following regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983: Diagnostic and screening procedures and Treatment of disease, disorder or injury. The trust has been inspected four times since 2014. It was rated good overall in 2014; in 2017 it was rated requires improvement; and in 2018 it was again rated Requires improvement. The trust's last comprehensive inspection was in November 2019 when it was rated as Requires Improvement. A focused inspection was carried out in November 2020. We did not rate at that inspection because we did not review all five key questions, we ask at comprehensive inspections.

CQC first became aware of the death of Ms. Hussain in May 2020 when notified by Birmingham and Solihull Mental Health Foundation NHS trust (BSMHFT) CQC requested information, specifically Ms. Hussain's risk assessment; care plan; continuation notes and incident reports. The information was used to carry out a review of Ms Hussain's care whilst on the ward.

The review of the information raised concerns about the quality of risk assessment and care planning taking place on the ward which led CQC to request information relating to other patients currently receiving care on the ward, Mary Seacole 2. As a result, CQC visited the hospital on 24th June 2020 to review patient records including risk assessment and care plans to understand the care that had been delivered on the ward. The team also spoke to the Matron and the Clinical Service Manager about the challenges currently on the ward the death of Ms Hussain.

The team met with members of the leadership team in July 2020 and provided feedback on areas of concerns that they found during their visit to the hospital and which needed to be addressed by the trust.

In November 2020, following a further death at the trust, CQC undertook a responsive inspection. There had also been several concerns received by inspectors about community services. Three inspection teams visited the trust to inspect their acute wards for adults of working age; Community mental health service for adults and Home treatment teams. That inspection resulted in enforcement action that placed conditions on the trusts registration of their acute wards for adults of working age.

The conditions placed on their registration were as follows:
1. By 4 January 2021, the registered provider must inform the Commission of the order of priority in terms of addressing the ligature risks and timescales for addressing the ligature risks across each ward.

2. The registered provider must take steps to address the ligature risks across all wards by 18 June 2021

3. By 29 January 2021 the Registered provider must implement an effective system to improve risk assessments and care planning. The Registered Provider must report to the Commission on the steps it has taken in connection with this by 5 February 2021.

4. Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of and including mitigating measures being put in place until all ligature risks are addressed.

5. Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective

Concerns identified in the Regulation 28 Report

The Regulation 28 report sets out the following matters of concern for CQC to address:

"BSMHFT had risk assessed ward 2 for ligature points, including the en-suite bathrooms, in November 2019. The en-suite bathroom doors were given the highest risk score possible on an acute ward, but no corrective action was identified to remove or mitigate the risk: the risk assessment relied on clinical assessment and observation of the service user to mitigate the risk. Evidence was given at the inquest that pressure sensor alarms have been available in the UK from numerous manufacturers for 10 years, BSMHFT had been investigating and testing different pressure sensor alarms for en-suite bathroom doors for approximately 2 years before Azra's death. BSMHFT has now identified an appropriate pressure sensor for en-suite bathroom doors and the en-suite bathroom door of room 14 on ward 2 was replaced in November 2020 with a door incorporating a pressure sensor alarm. BSMHFT has a 17 month program to fit pressure sensor alarms to all en-suite bathroom doors within its inpatient units. However, this is not being considered for other doors within the bedroom area nor is there any national requirement for inpatient mental health units to place, or consider placing, pressure sensor alarms on doors within areas where patients are afforded privacy and time alone. I am concerned that within BSMHFT's inpatient units there will be a continuing risk from other doors in the bedroom area (including the main bedroom door) even when the en-suite bathroom doors are fitted with pressure sensor alarms. Although the outer face of a bedroom door will be on a communal corridor, service users on level 1 and 2 observations will have periods where they are unobserved in their rooms and could wedge a ligature at the top of a door so that it wasn't obviously visible from outside. Furthermore, in the absence of any national regulations or guidance on this topic the risk from en-suite and other doors in areas

where service users spend time unobserved will persist in mental health units operated by other Trusts and private providers around the country"

There is currently no national requirement, regulations or guidance for in-patient mental health units to place pressure sensors on doors. Any such guidance would be produced by NHS Estates in their building's guidance. When CQC inspects a service of this nature, as part of the inspection we check the providers compliance with ligature risks as part of the safe domain and we check the environment is suitable for use as part of our assessment. An inspection team would not check specifically for pressure sensors on doors. If we find ligature risks to be present, we establish if the trust has identified and mitigated that risk. Failure to do so represents a breach of regulations that may result in enforcement action.

Conditions were placed on the trust's registration certificate by CQC following the inspection on 23 November 2020 which identified concerns in relation to ligature risks, risk assessment and care planning. The Trust has complied with our conditions and have been submitting monthly updates on their progress to replace doors and improve care planning. Inspectors have been meeting monthly with the trust leadership team to discuss the progress and improvements made to date. As a result of the meetings CQC has asked for weekly reports on the ward improvements programmes to understand ongoing mitigation whilst the replacement of en-suite doors is incomplete.

The CQC has been informed by the trust that it is reviewing the timetable submitted for the replacement of the en-suite bathroom doors as requested by their clinical governance committee. They have sought independent review from the NHS England's quality and safety team who will present their report to the trust in May 2021.

Bedroom doors did not feature as part of the conditions placed on the trust however the trust has informed CQC that they are reviewing bedroom doors as part of their overall improvement strategy.

We will check the provider's compliance with the regulations on our next inspection of the service using our key lines of enquiry and in accordance with CQC's regulatory remit, highlight breaches of regulation to the provider and/or registered manager ('registered person') if warranted and ask them how they will make the necessary improvements. Our next inspection of the service is not yet confirmed, however CQC have adopted a more risk-based approach to inspections should we receive negative intelligence or have further concerns about the service we would carry out responsive inspections.

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 Ms Hussain with inspectors and registered persons.

We hope that this response addresses your concerns. If this is not the case, please could you clarify any further details you require.

Yours sincerely

[redacted]

Head of Inspection
Hospitals (MH and CHS) – Midlands and East