	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Stars Social Support Limited** **2. Care Quality Commission** **3. South West Yorkshire Partnership NHS Foundation Trust**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 10 April 2018 I commenced an investigation into the death of Anthony Wilkinson born on 31 December 1960. The investigation concluded at the end of the inquest on 26 March 2021. The conclusion of the inquest was Unlawful Killing. Anthony died as a result of 1a: Foreign Body obstruction of the airway
4	**CIRCUMSTANCES OF THE DEATH** Anthony Wilkinson ("Tony") was diagnosed with Fragile X syndrome. He lived relatively independently with support for much of his adult life and was able to access the community and undertake hobbies and interests without too much difficulty for much of his life. His overall health started to decline in late 2017 and he began having investigations for dementia or similar neurological decline. The primary symptom of this which was exhibited was of unusual and more erratic behaviours including aggression and physical and verbal confrontations. One additional issue which arose with Tony was some swallowing difficulties. This led to Speech and Language Therapy Assessments being undertaken in 2017 and 2018. The first regarded Tony has having behavioural swallowing difficulties which meant that he crammed too much food into his mouth or put food into his mouth without swallowing what was already in his mouth. Speech and Language Advice in 2017 was that Tony should be supervised at all times when eating and should have a softened diet. This advice was never incorporated into Tony's support plans or risk assessments by the care provider. Tony was provided with a meal on 18 February 2018 which resulted in him choking and having to be admitted to hospital. The meal that he was provided with in February 2018 was in line with the SALT advice from 2017 but resulted in a further referral to the SALT team. When SALT visited on 5 and 6 March 2018 it was apparent that there was a deterioration in Tony and that his swallowing difficulties were now due to a mechanical issue with his swallow. As a result, they advised that Tony should have a fork mashable diet and thickened fluids. Again, this was not incorporated into a support plan at Tony's address for carers to access and utilise.

Staff did indicate that they were aware of the need for fork mashable diet and thickened fluids however the communications log showed variable compliance with the specialist diet.

The care provider advised that support plans were generated at the head office and was then printed twice with a duplicate copy taken to the resident's home address. The care provider also advised that they would collect the communication logs and important issues sheets along with some other documentation from the resident's file once a month to audit for compliance and recording standards and then archive these at Head Office. It was apparent that the care co-ordinator in Tony's case was on annual leave and sick leave in the two weeks prior to Tony's death and was not able to advise when the sheets had last been collected but when the police took Tony's record from his home address the communication logs only went back to 28 March 2018 (Tony having died on 4 April 2018)

The Police carried out an investigation into Tony's death and found that no criminal charges would follow his death as matters could not be proven beyond reasonable doubt. Of course, the coroner's proceedings only require matters to be proven on the balance of probabilities even where that relates to a finding of unlawful killing.

Following the evidence at the inquest the jury concluded that Tony had been unlawfully killed. They were asked a series of questions which formed box 3 of the record of inquest which required unanimous yes or no answers. They were answered as follows:-

a. Were Stars Social Support Limited responsible for the care and support needs of Tony between 4 December 2017 and 4 April 2018? **Yes**

b. Was part of the role which Stars Social Support Limited had translating specialist advice into support plans and risk assessments for Tony? **Yes**

c. Following the SALT assessments of 4 December 2017 and 5/6 March 2018, did Stars Social Support Limited put in place a robust procedure to implement the advice provided in Tony's support plans and risk assessments? **No**

d. Did the support plans for Tony which were at [redacted] adequately reflect the risks posed to Tony following the assessment by SALT on 5/6 March 2018? **No**

e. Were the support plans and risk assessments at Midland Road between 5 March 2018 and 4 April 2018 adequate to enable staff to mitigate the risks posed to Tony as a result of his swallowing difficulties? **No**

f. Following the SALT assessments of 4 December 2017 and 5/6 March 2018, did Stars Social Support Limited put in place adequate and robust communications to staff caring for Tony so that they were aware of the advice? **No**

g. Following the SALT assessment on 5/6 March 2018 did Stars Social Support Limited senior managers review whether staff were implementing the advice? **No**

h. Were staff aware of the expectation that they would attend head office to review service user support plans and risk assessments as part of their role in supporting Tony? **No**

i. In view of the SALT advice, was Tony provided with appropriate food when he visited the Manchester Airport pub with a support worker from Stars Social Support Limited? **No**

	j. Was Tony provided with safe care by Stars Social Support Limited between 5 March 2018 and 4 April 2018? **No** Following Tony's death, the Care Quality Commission inspected Stars Social Support. They attempted to do so in 2018 however the Police had seized a significant amount of documentation and therefore they believed that they were not in a position to carry out an inspection of the services at this time. As a result of that the inspection triggered by Tony's death was not until 13 February 2019 and the subsequent report was released in May 2019. This inspection found that the services 'required improvement' overall with breaches of the Regulations. This would automatically trigger the requirement for a re inspection within 12 months of the published report (therefore the next inspection was required by 8 May 2020) Due to the breaches of the Regulations found, Stars Social Support were also required to provide an action plan within 28 days of the rating to commence improvements. CQC state they did not receive any action plan from Stars Social Support Limited following this inspection. CQC did not return to the Provider to inspect until August 2020 which they confirm was due to the pandemic and not entering providers to inspect during this time. To mitigate this CQC determined they would risk stratify the providers and those that were high risk would receive priority monitoring and be the first inspected when they were able to return to inspection activity. CQC did not rate Stars Social Support as one of their higher risk providers at this time. When CQC returned in August 2020 and reported on this inspection in October 2020 they determined that the provider was now rated as 'inadequate' overall. There were further breaches of the Regulations at this time. Again, the provider did not provider an action plan following this inspection. Although the advice which Tony was given by Speech and Language Therapy was not a feature of the inquest proceedings the SALT team have subsequently updated their advice and guidance sheets and I will return to this feature of the proceedings below.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – <u>Stars Social Support Limited</u> (1) Stars Social Support Limited have a culture which does not encourage transparency or embrace the duty of candour. This was evidenced throughout the inquest proceedings and in the lack of engagement with CQC during the inspection regime. (2) Stars Social Support Limited do not utilise their own website to ensure that policy and legislative changes can be adequately and promptly shared with service users, their families, and staff. (3) Stars Social Support Limited do not have appropriate policies, procedures and checks in place to ensure that updates to care plans are communicated to all staff caring for service users or that the correct care and support plans, and risk assessments, are in the service users home address. (4) Stars Social Support Limited have implemented the use of WhatsApp to ensure staff are aware of updates to service users plans and they require staff to confirm they have read and understood the update prior to caring for an individual. Whilst this is a positive use of technology to support staff in caring for service users it is in itself a safeguarding issue to hold personal information about the service user on personal mobile phones; this is especially the case

where there are not adequate policies in place around the use of personal phones by staff members.

(5) The use of the WhatsApp group adds in two risks of its own, the first is that there is an over reliance on this being the means by which service users care plans are updated and by default this ends up being the service users care plan. This makes it more likely rather than less likely in my view that support plans in the service users' home will not be updated in a timely fashion.

(6) Secondly, visiting professionals are not able to access the WhatsApp group and therefore will not be in receipt of this updated information which may be important for some service users.

(7) There was no evidence that fundamental matters such as standard operating procedures for displaying SALT advice or allergy advice in a service users' kitchen where all can see it have been implemented by the Stars Social Support Limited.

(8) There remained a lack of understanding about the mental capacity act and how that may affect the care delivery to service users where it meant that a carer or senior manager had to be the decision maker for specific aspects of their care such as nutrition or medication

(9) There is now a significant reliance on the Director updating all records and delivering care and undertaking audits whilst she improves the culture of the organisation. There was no adequate description of contingency plans in the event of sickness of this individual.

(10) The Director, in evidence, did not describe consideration of a lead carer for service users who would hold some responsibility for ensuring documentation in the service users' home was accurate and up to date.

(11) I did not hear or see any evidence of any policy or procedure being in place at the Stars Social Support Limited which related to completion of risk assessments and care plans; where they will be kept; how they should be updated; who will look at them and where; what to do in the event that there isn't one; how documents should be presented; how technology will be used; how data will be safeguarded; how audits will be undertaken; how handovers will be undertaken. This list is not exhaustive it is simply a list of some of the areas I am particularly concerned about in this case however I have not seen evidence of any policies produced by Stars Social Support Limited despite asking specifically for this at the end of the inquest proceedings. I have seen only an induction booklet.

(12) I would like to see evidence of how Stars Social Support Limited will positively engage with Regulators and other bodies to enhance the quality of their services.

<u>Care Quality Commission</u>

(13) CQC did not take adequate steps to access records held by the Police or the provider in a timely fashion following Tony's death. This potentially created risk to other service users as the Regulator had not inspected the service promptly following a significant event.

(14) CQC too readily accepted the lack of an action plan from the provider and did not use this lack of engagement from the provider to increase the risk profile for this provider. Had they done so an earlier re inspection may have been triggered or further regulatory action. This failure may have exposed other service users to unnecessary risk of harm as a result of an inaccurate risk picture being provided by the CQC.

(15) CQC did not take into consideration significant relevant factors when risk assessing this care provider at the start of the pandemic leading to an inappropriate risk profile being established and an exaggerated level of confidence being placed in the provider to provide safe services to residents without appropriate monitoring and oversight from the Regulator.

(16) The report from the August 2020 inspection was inaccurate and misleading and may have caused service users to be added to this service where that ought not to be the case. The report published in October 2020 refers to their being no

	evidence of harm however there is a woeful lack of detail about the context of this within the report. CQC should review this particular report for this provider and also reconsider the way in which reports are written to ensure that they are not misleading and therefore dangerous. This includes either omitting from the report any comment about harm where there is clearly a context and evidence of harm to service users previously, which is open and live, but which does not form part of the inspection or very clear confirmation in the report that there has been evidence of harm which does not form part of the specific inspection report. (17) Where CQC are required to decide whether evidence ought to be used for the basis of an inspection OR for regulatory action, they ought to ensure there is a consistent approach to this including the consideration of polices and standard operating procedures. This should be approached on the basis of safeguarding the majority of remaining service users from harm being the priority even where that means prosecutions for breaches of Regulation may be compromised. <u>South West Yorkshire Partnership NHS Foundation Trust</u> (18) The advice from SALT was not an issue in this case, it was the application of this advice which was the primary concern. I would like to commend the approach that the Trust have taken in learning from the issues which I raised at the conclusion of the proceedings and the openness with which the Trust have received the concerns I had. The guidance sheets which have been produced are still not clear enough and will lead to confusion including around the consistency description and a list of foods which can be modified or should be avoided. This needs to be reviewed to avoid confusion.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. I would ask that your responses specifically consider the following:- <u>Stars Social Support Limited</u> 1. Stars Social Support Limited should reconsider its use of technology in support service users including the use of software applications for the storing and creation of records. 2. Stars Social Support Limited should review its use of its own website for the updating and storing of policies. 3. Stars Social Support Limited should urgently put in place processes for the development of training and mentoring in relation to the culture of the organisation to encourage openness, transparency and the duty of candour which is a fundamental part of care delivery. 4. Stars Social Support Limited should review its processes around the displaying of critical advice around service users' homes 5. Stars Social Support Limited should give consideration to the use of a single member of a service user care team to act as the lead for ensuring the plans in the service users home are up to date and maintained appropriately 6. Stars Social Support Limited should urgently ensure that it has adequate policies and procedures in place which ensure the safety of all of its service users. The Induction Booklet alone is not sufficient to achieve this aim. 7. Stars Social Support Limited should consider a pledge and commitment to work collaboratively and co-operatively with the Care Quality Commission and other statutory partners to ensure high quality and safe care can be provided to service users.

	Care Quality Commission 8. Care Quality Commission should urgently review the report related to this provider from October 2020 and correct any errors or misleading statements within it. 9. Care Quality Commission should review its processes where their regulatory functions collide with criminal investigations to ensure that timely regulatory oversight and action is taken notwithstanding police, HSE or indeed CQC prosecution activity. 10. Care Quality Commission should review the presentation of its reporting to ensure that where statements such as 'we found no evidence of harm to service users' are placed in the context of the inspection. For example, statements should be read as 'This service has 90 service users. We inspected 9 records as part of our inspection, and we validated these records against the care provided to those service users. We checked the records held by the Head Officer and did not confirm that these were replicated in the service users home address. Of those records we did not find any evidence which would support breaches of Regulations relating to the delivery of safe care'. The organisational context of an inspection is as important as the individual outcomes found on the day of the inspection; indeed, it is the context which sets the inspection intervals. 11. Care Quality Commission should review the way in which it treats evidence which relates to inspection standards and breaches of Regulations (including criminal offences) where that evidence relates to the same actions. South West Yorkshire Partnership NHS Foundation Trust 12. The Trust is invited to consider the guidance leaflet in the context of the statement provided to me for the hearing on 9 April 2021. This includes separation of the columns related to foods to avoid and those which can be manipulated; correction of the images which appear to endorse foods which ought not to be endorsed and clarity around the consistency of the diet not to sit alongside potentially confusing statements such as fork mashable meaning something which can be picked up with chopsticks.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 June 2021. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, Tony's family; Stars Social Support Limited; [redacted]; Care Quality Commission; Barnsley Metropolitan Borough Council; South West Yorkshire Partnership NHS Foundation Trust I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**13th April 2021**  Abigail Combes **HM Assistant Coroner**