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Mrs. Joanne M. Lees
Area Coroner
The Black Country Jurisdiction
Coroners Court,
Jack Judge House,
Halesowen Street,
Oldbury, B69 2AJ

06 April 2021

Care Quality Commission
Our Reference: [redacted]

Dear HM Coroner

Prevention of future death report following inquest into the death of Mr Eric Harold Bird.

Thank you for sending CQC a copy of the prevention of future death report issued following the death of Mr Eric Harold Bird.

We note the legal requirement upon Castlehill Specialist Care Centre and the Care Quality Commission to respond to your report within 56 days.

The provider location registered with CQC is located at 390 Chester Road, Walsall, WS9 9DE and is part of the Walsall Clinical Commissioning Group. The provider is registered for the following regulated activities:

Accommodation for persons who require nursing or personal care
Treatment of disease, disorder or injury

The CQC was notified of Mr Bird's death on 09 December 2020 by West Midlands Police. West Midlands Police informed the CQC they did not feel there was anything criminal to investigate and were closing the case. The CQC contacted Castlehill Specialist Care Centre as a statutory notification had not been received. There had been a delay from Castlehill Specialist Care Centre in sending the notification due to Mr Bird passing away in hospital. Castlehill Specialist Care Centre notified the CQC of the death on 11 January 2021.

An inspection had already been prompted following whistleblowing concern in relation to restraint, deprivation of liberty safeguards, staffing levels and falls

management. A large-scale safeguarding investigation (LSI) meeting was held on 18 December 2020, where inspector [redacted] attended. The LSI was subsequently closed on 25 January 2021 as an outcome the local authority quality team were asked to provide ongoing support in relation to falls management. We also noted the content of the LSI and used this to support our future planning of inspection. The inspection process would assess any likely future risks.

The provider was inspected by CQC on 19 January 2021 in the form of a comprehensive inspection which assessed five domains; Safe, Effective, Caring, responsive and Well Led. No enforcement action has been proposed as a result of this inspection. The provider received the draft report on 22 March 2021. As part of the report publishing process, the Provider is then given the opportunity to review the draft report before it is finalised. If the Provider believes there are any factual inaccuracies in the report these can be submitted to the CQC and will be considered before the final report is published.

The matters of concern which arose from the preventing future deaths report have prompted the CQC to take action. In direct response, we held a management review meeting on 17 February 2021. Following the management review meeting, we reviewed the evidence we held about Castlehill Specialist Care Centre, the information held following the specific incident review related to Mr Bird's death and information following the inspection completed in January 2021.

Our findings and actions are outlined as follows:

On 09 December 2020 we began to request and review the information we had following Mr Bird's fall and death in line with our specific incident guidance. So far, we have found the following:

- We reviewed the care plan and risk assessment Castlehill Specialist Care Centre had implemented in relation to Mr Birds falls risks. Mr Bird had been identified as a high falls risk but was able to mobilise independently.
- Castlehill Specialist Care Centre had implemented care plans and risk assessments for staff to support Mr Bird with falls management. There was no mention of what action staff should take if Mr Bird sustained a head injury. However, on the fall that subsequently led to Mr Birds death, staff did seek medical intervention.
- Castlehill Specialist Care centre have confirmed there was no referral made to physiotherapy during Mr Birds stay between 20 October 2020 and 21 November 2020.
- Castlehill Specialist Care Centre told us they had not identified blood thinners as a risk as part of their medicines policy. They told us the lesson learnt would be to put a statement in their medication policy that this type of medication group thins the blood.

- As a result of these findings, CQC held a management review meeting on 18 March 2021 to discuss the findings under our specific incident guidance. In order to open a formal criminal investigation, we have to be able to evidence a Registered Person (either a Registered Provider or Registered Manager) failed to provide safe care and treatment to Mr Bird in relation to this incident and can prove beyond reasonable doubt this incident was avoidable. We did not feel that this threshold was met and therefore will not progress the case.

As a result of the findings an inspection was carried out on 19 January 2021. The inspection found the following:

- Care plans and risk assessments record updates have been made following falls and contain details of the falls. Reviews in care plans indicate a frequency of more than monthly and reviews have been done as and when care needs changed, or contact was made with health professionals.
- Review sections in care plans have been updated as and when contact has been made with external professionals.
- Where service users' medicines may cause drowsiness and increase risk of falls, this is identified in care plans and risk assessments. Medical advice has been sought for service user when their needs have changed, for medicines to be reviewed.
- Analysis of trends in incidents and accidents across the home occurred to determine whether any further action could be taken to mitigate risks to people.
- There were systems in place to review incidents and accidents on an individual basis to reduce the chance of a similar incident occurring again.
- Following analysis, a referral to the local falls team has been made for one service users. In addition, night monitoring had been changed for another person. There were details of where staffing levels had changing to meet peoples need.
- There had been falls recorded where no injuries were sustained so therefore no medical attention needed. Care plans stated that staff should monitor every four hours for 24 hours following a fall.
- The operations manager carried out a monthly quality assurance tool where falls management was checked. This tool would identify if any patterns or trends of falls had not been addressed. There were no concerns identified in the quality assurance tool.
- Records showed healthcare professionals had been involved for other healthcare conditions, for example occupational therapy and tissue viability nurses. The service acted appropriately to changes in healthcare needs. The GP was conducting twice weekly ward rounds via Zoom.
- There were many good aspects of monitoring within the service such as audits on safeguarding, activities and wellbeing and Benzodiazepine usage. Where improvements were needed, an action plan was put in place and followed up.

- On the day of inspection when the inspector arrived on site a person had fallen, and an ambulance was present. The manager was analysing what could be done to prevent reoccurrence and we had a discussion where the manager said they do not wait until the end of the month to review incidents/accidents but do this as and when they occur.

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Finally, please include the reference number [redacted] if you require any further information from us.

Thank you in advance for your assistance.

Yours sincerely

[redacted]

CQC Inspection Manager