Care Quality Commission

HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Mary Crane
HM Coroner

24 November 2021

**Care Quality Commission**

Dear HM Coroner

**Re: CQC Response to Regulation 28 Report - Mr Stephen Verrall**

Thank you for sending the Care Quality Commission (CQC) a copy of the prevention of future death report dated 1 October, issued following the death of Mr Verrall. We are writing to you with our response to the concerns raised within your report.

At CQC, we make sure that health and care services in England provide people with safe, effective and high-quality care. We monitor, inspect and rate the quality of care of providers and highlight to them where they need to make any improvements in their standards of care. If they do not meet the legal requirements as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we take action to make sure they improve.

Following the inquest we carried out a responsive "targeted" inspection of St John's Nursing Home. "Targeted" inspections do not change the rating from the previous inspection but allow us to identify areas requiring action from the provider. This is because they do not assess all areas of a key question.

We carried out the inspection on 13 October 2021 in response to your concerns and to information shared at the inquest by the provider where they told the inquest that they had identified a further 17 windows that were without an adequate restrictor and posed a risk to people. We also followed up on our Warning Notice to check compliance.

At this inspection people's safety was still at risk as they were not cared for in an appropriately safe environment. Windows had still not been appropriately restricted to protect people from the risk of falling from height, and there were concerns about the security of the building. We identified breaches in relation to the regulations (12 - Safe Care and Treatment and 17 - Good Governance). Following the inspection, we received evidence from the provider that action had been taken to ensure the windows were now made safe and appropriate restrictors fitted.

However, we remained concerned about governance at the service including the effectiveness of audits.

After our inspection we asked the provider to submit a copy of their environmental risk assessment. We found this assessment continued to not appropriately assess and mitigate the risks to people of falling from height and we will be taking action to address these concerns.

CQC's response to the specific concerns you have raised in your report are taken in turn and set out below:

1. **Care Quality Commission – I was informed that CQC did not routinely check window restrictors on inspections. I was told that it was the responsibility of providers to comply with regulatory requirements in this regard. Whilst that is uncontroversial, the death in this case, and the fact that there remained unrestricted windows in August 2021 nearly four years after this death, demonstrated that checks by the regulator are required. Responsive checks after incidents are not sufficient to prevent deaths.**

At the inquest hearing held between 27 and 30 September 2021, [redacted] provided a statement in relation to this concern.

"During our inspections, inspectors do not routinely check window restrictors as part of an inspection. However, inspectors may check some restrictors where observations on the day or information we receive prior to inspection identifies concerns. However, inspectors will check the systems and processes are in place to enable the provider to assess and monitor the quality of services and to identify, assess and manage risks to ensure people are protected against the risks of receiving inappropriate or unsafe care or treatment. It is care providers responsibility to ensure there are adequate window restrictors in place. It is also the provider's responsibility to carry out adequate checks on the window restrictors to confirm that they are sufficiently robust and complied with the relevant guidance."

We exhibited the following published guidance.

Window restrictors - estates and facilities alert EFA/2013/002 - GOV.UK (www.gov.uk)

Falls from windows or balconies in health and social care (hse.gov.uk)

Health Building Note 00-10 Part D – Windows and associated hardware (england.nhs.uk)

Following the hearing we have met with the CQC Policy team to discuss your specific concerns and how they relate to the regulatory requirements, in particular, Regulation 12, Safe Care and Treatment Regulation 12: Safe care and treatment | Care Quality Commission (cqc.org.uk), Regulation 15, Premises and equipment Regulation 15: Premises and equipment | Care Quality Commission (cqc.org.uk) and Regulation 17, Good governance Regulation 17: Good governance | Care Quality Commission (cqc.org.uk).

The policy position and regulatory requirements remain unchanged. We are not intending to introduce a routine requirement for CQC inspectors to check window restrictors during site visits. Effective risk management by providers will continue to form part of our current assessment framework covered in the Safe key question Managing risks | Care Quality Commission (cqc.org.uk), and there will be a specific focus on this in our new single assessment framework which is currently being developed as a key part of our future regulatory model. In the new framework there will be a quality standard relating to safe environments and delivery of care. The exact wording is to be confirmed, but it will cover the expectation for providers to detect and control potential risks in the care environment and make sure that the equipment, facilities and technology support the delivery of safe care.

2. **St John's Nursing Home –I heard that Stephen had managed to leave the home unaccompanied on several occasions. The opportunity to do so for those without capacity and without the ability to assess risk poses a risk to their lives. I was told that the reception is not manned on the weekends and there is a risk that residents may follow visitors through the door when they leave.**

In addition to inspecting St John's Nursing Home on 13 October 2021, we also wrote to the registered provider on 21 October 2021 and asked them to provide any further information and supporting evidence about the action they have taken or intend to take in response to your report. We received a response from the registered provider on 22 October 2021.

The provider supplied additional evidence to address the concerns about the security of the premises and the plans they had in place to ensure people did not leave the service unaccompanied, when it was unsafe for them to do so. We will check at our next inspection that these changes have been embedded at St John's Nursing Home and that these were effectively minimising risks where these had been identified.

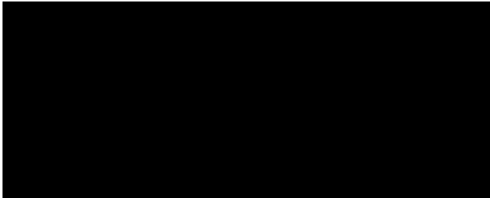
However, we remain concerned that the provider continued to not have effective and robust systems to assess, monitor and mitigate risks to people's safety. While there are governance systems in place to review the health and safety of the environment, these had not been effective in identifying and addressing the concerns we found during our inspections. Regular audits and checks on the safety of the environment had been undertaken but they had failed to identify the risks to

people's safety and the provider did not have effective systems in place to learn from previous incidents. We have identified a continued breach of Regulation 17 Good Governance.

CQC are progressing regulatory action in relation to these concerns. Full information about CQC's regulatory response to more serious concerns found during inspections is added to reports after any representations and appeals from the provider have been considered and concluded. However, the current inspection report can be found on our website https://www.cqc.org.uk/location/1-160800488/reports.

Should you require any further information, please do not hesitate to contact the Inspection Manager for the service, [redacted], [redacted]

Yours sincerely



**Head of Inspection, London**