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29th December 2020

Chris Morris
HM Area Coroner
Greater Manchester South

Dear HM Area Coroner Mr Morris,

Regulation 28: Report to Prevent Future Deaths William Ivan McKibbin

I have received your regulation 28 report following the inquest into the death of William Ivan McKibbin at Trafford Hospital on 20th August 2018. As [redacted], Chief Executive is currently on annual leave I am responding to you on behalf of the Care Quality Commission (CQC).

This response relates to the matters of concern raised in your report, specifically you ask CQC to address the following:

In order to enhance learning from deaths, consideration should be given to modifying the Statutory Notification process following the death of a service user so as to require Registered Providers to lodge specified relevant evidence as to how the death occurred within a defined period.

CQC are the independent regulator of health and social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

The notification requirements in relation to a death of a service user are contained within Care Quality Commission (Registration) Regulations 2009: Regulation 16 (1), (2) & (3),which states:

> **16.**—(1) Except where paragraph (2) applies, the registered person must notify the Commission without delay of the death of a service user—
>
> (a)whilst services were being provided in the carrying on of a regulated activity; or
>
> (b)as a consequence of the carrying on of a regulated activity.
>
> (2) Subject to paragraph (4), where the service provider is a health service body, the registered person must notify the Commission of the death of a service user where the death—
>
> (a)occurred—

(i)whilst services were being provided in the carrying on of a regulated activity, or

(ii)as a consequence of the carrying on of a regulated activity; and

(b)cannot, in the reasonable opinion of the registered person, be attributed to the course which that service user's illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment.

(3) Notification of the death of a service user must include a description of the circumstances of the death.

The duty to notify CQC directly does not apply if and to the extent that the registered person has reported the death to the National Health Service Commissioning Board which is interpreted in CQC's published guidance (CQC's published guidance for NHS providers) to mean NHS England's National Reporting and Learning System (NRLS).

This guidance indicates that NHS providers should notify relevant deaths to the NRLS using their LRMS or relevant eForm. These reports must meet the standards for the relevant mandatory fields. In relation to these standards, every NHS organisation should report patient safety incidents with an actual degree of harm of either "severe" or "death" to the NRLS within two working days of the incident occurring.

The NRLS staff guidance for completion of e-forms states:

- Please describe the patient safety incident in your own words. It is important that the information you provide is factual and not simply an opinion.
- Think about the sequence of events. Try to identify who was involved at the different stages and their particular role (but do not give any names). End with a description of how the incident was concluded.

As such specific and relevant information should be reported within a short period following the death of a service user. Serious Incidents (as defined in the Serious Incident Framework 2015) are also reported to the Strategic Executive Information System (STEIS).

CQC then obtains the relevant information about an incident through our information sharing processes. Key information from the NRLS/STEIS reports is made available for review by the relevant CQC inspection team, who decide whether to follow up with the relevant provider about the incident.

Our inspection lead for Trafford Hospital reviewed the NRLS/STEIS incidents in relation to the death of Mr McKibbin on the 30th October 2018. The reports indicated that his fall was unwitnessed and that he was found face down on the floor with obvious injuries; that he acquired a large subdural haematoma and was reviewed by

the neuro team at Salford, but was not appropriate for surgical intervention; that he was placed on an end of life care plan and, that his death was unexpected/ potentially avoidable.

The reports did not include the full details of the events leading to Mr McKibbin's death although there is provision in NRLS and STEIS for these details to be reported. On consideration, our inspection lead found that in this case sufficient information was provided in order to fulfil our regulatory role.

There was a comprehensive inspection of the trust including Trafford Hospital over a four week period in October 2018 and a well led inspection in November 2018. The hospital was rated as good. Inspectors review incidents and other patient safety information before, during and after inspections to inform the on-site visit and the subsequent report.

At the inspection we found that:

- The trust told us it had a quality and safety strategy 2018 - 2021 which focused on a range of quality and safety priorities. For instance, reducing the number of falls that result in harm to patients. As an example of this, we attended a falls meeting, attended by ward managers, where staff openly shared cases of falls to explore what could be done differently and share organisational learning.
- The trust had a process for ensuring that deaths were reviewed within at least one month of the death using the structured judgment review method with any learning presented to group/hospital level mortality groups. The trust's standardised mortality ratio was within the 'as expected' range.

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in medicine at Trafford General Hospital which met the reporting criteria set by NHS England from October 2017 to May 2018. Three of these incidents were for patients with slips, trips or falls, and one was due to treatment delay meeting the SI criteria.

Our inspection team reviewed a root cause analysis report for one of the serious incidents above and found actions plans and lessons learnt were identified. Actions included providing further training or feedback to staff.

The current arrangements by which CQC receives notifications of deaths via the NRLS rather than directly from NHS Trusts was put in place to reduce the complexity of reporting routes and minimise burden on NHS providers. Although direct notifications to CQC contain questions which have the potential to elicit more detail about a specific incident, the quality of the data is equally dependent on staff reporting culture and practice.

Any changes to the current arrangement for reporting of deaths would require legislative change brought forward by the Department of Health and Social Care. CQC's view is that creating a separate, and potentially parallel reporting requirement for providers could create confusion and undermine appropriate reporting to both routes with an impact on national learning from patient safety incidents. Therefore,

our preferred option is to continue to receive this information through the NRLS /STEIS routes and promote the right level of reporting through our regulatory activities.

In general, we consider that the information received through NRLS/STEIS reports is adequate to enable CQC to fulfil its regulatory responsibilities. However, we will review our existing notifications guidance in light of the findings from Mr McKibbin's death, to determine if it could be clearer about the reporting requirements relating to the circumstances of a person's death. We have a programme to improve how we receive, analyse and assess the information we receive via NRLS and STEIS to monitor patient safety.

Kind regards,

[redacted]

Chief Inspector of Hospitals