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Our Reference: POCU 2223 0297

24 November 2022

Dear Dr Alexander,

Thank you for your email of 12 October.

Our internal guidance requires that we carry-out what we term an “Initial assessment” of any incident where there has been an unexpected death or severe harm. In carrying-out this assessment local inspection teams are firstly looking to assess and respond to any potential ongoing risk, as a priority, and then subsequently they consider if the facts of the incident may point towards a potential offence (for which we have jurisdiction) having been committed.

Prior to Emma Carroll’s email of 17 August 2018, the local inspection team had convened four separate meetings, requested various records from the trust and sought the advice of our National Professional Adviser for Maternity at that time.

After those meetings and consideration of the information at hand, the local team, at that time, could not establish whether a potential offence had been committed. To establish a relevant offence, they would need to establish a breach of a relevant regulation, that this breach cased avoidable harm or put someone at risk of avoidable harm, and that the breach was a failure that could be attributed to the provider (as a registered person) and not an individual.

When Emma Carroll drafted her email of 17 August 2018, the local team, based on the information they had available at that time could not establish all of these elements. However, in Emma’s email, she unfortunately used conclusive language. After the conclusion of our prosecution. we carried-out a learning review of the investigation and within that we highlighted Emma’s correspondence to the family in August 2018. The learning point was that, for any potential offence and after any initial assessment, further information can always come to light and therefore we should not use categorical language in our communication with victims and families which states a conclusive position.

However, at the time of writing the email, we had not established the relevant breach and we had not established a failure by the registered person. That is what Emma was seeking to convey. Obviously, we did subsequently establish both of these elements of the offence – however, we did not establish this until a significant time later after we had moved from the initial assessment to a formal investigation.

In that same email in August 2018, Emma also wrote "*We have not received confirmation from the senior coroner as to whether they will be progressing with an investigation. However, I have requested CQC are made an interested party which means we will receive the final Coroner's report."*

There is only one reason why Emma would have sought for CQC to be made an interested party. That reason is that further information could come to light to inform the initial assessment further. So even though Emma's language read as conclusive, she knew the inquest may provide us with further information.

Around the time of Ted Baker's email in September 2018, the local team held two further meetings, when they considered the information available to them at that time. That is why Ted wrote to say that the investigation (although technically we were still at the initial assessment stage) was continuing.

As you say in your email, yes, clearly there was a breach of regulation 12 but this was not established at the time of either of these communications. You have asked a general question around organisational failings at East Kent Hospitals University NHS Trust and regulation 12, but please note that the assessment of a breach of regulation 12 in this specific instance was only related to the incident itself and not the provider generally.

In terms of what materially changed between the correspondence you have referred to and the prosecution; it was that through further initial assessment (and then by subsequently carrying-out a formal investigation), we established that an offence had been committed and we made the decision to prosecute the trust.

In response to your question on the Royal College's report, CQC had been made aware of the Royal College of Obstetricians and Gynaecologists report prior to 2019, but it is correct that the earliest record we have of CQC obtaining a copy of the report is in January 2019.

I will address your final three questions, as below, together.

"*The Richfords, like many other harmed families, report that CQC initially told them that it could not investigate individual complaints.*

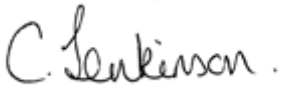
Does the CQC accept that this appears to be incompatible with its duties under Regulation 12?

How can the CQC establish if harm has occurred under Regulation 12 if it does not investigate individual cases?"

There is a distinction here between individual incidents and individual complaints. It is correct that CQC does not have a role in the resolution of individual complaints. It

does, as I have explained at the beginning of this letter though, have a role in assessing specific individual incidents as it did in the case of Baby Harry Richford. Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides a requirement on providers around safe care and treatment, it is one of our “Fundamental Standards”. In assessing specific incidents, the CQC can determine if there has been a breach of a relevant fundamental standard. Where we are assessing a specific incident and the victim or family have made a compliant to the NHS trust also about this incident, we would consider that correspondence as part of our assessment.

Yours sincerely,



Carolyn Jenkinson
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