From: REDACTED
To: REDACTED
Sent: Thursday, 1 June 2023 at 23:54:00 BST
Subject: Audit of CQC's application of Regulation 12 and failure by CQC to prosecute within legal time limits in the case of Sally Lewis

BY EMAIL

Health and Social Care Committee, Parliament
1 June 2022

Dear Mr Brine and colleagues,

Audit of CQC's application of Regulation 12 and failure by CQC to prosecute within legal time limits in the case of Sally Lewis

I write to ask if the Committee has any identified date yet for the next accountability hearing with the Care Quality Commission and to ask that whenever a hearing is next held, that CQC's response to statutory death notifications, application of Regulation 12 and pursuit of related investigations and prosecutions are given attention.

This is because of serious ongoing concerns.

The committee may recall that the Mazars review of Southern Health in 2015 revealed hundreds of deaths of mental health and learning disability patients that had not been investigated.

Compounding this, a CQC inspection in 2014 which had preceded the Mazars investigation failed either to identify or report this gross failure of safety practice.

Mazars also identified a fatal flaw in what was then a major plank in what was then CQC's revamped inspection regime - the so-called "intelligent monitoring" system.

Mazars concluded that the system was flawed by the fact that CQC was not being notified of all deaths.

"Intelligent monitoring" was later dropped by the CQC.

Unfortunately, CQC's handling of clear and serious care failures that are due to organisational and systemic failings continues to give concern.

The latest example is the CQC's serious mishandling of the death of Sally Lewis in supported accommodation and failure to prosecute in time, even though this was a clear cut case and all the relevant evidence was available from an early stage.

In how many other cases is this happening?

Sally Lewis' family fought for her, but not all victims will have advocates, and not all families will be able to fight.

As far as I am aware, the CQC has given no adequate public account of itself in this matter.

In another related matter, the late CQC prosecution over the death of baby Harry Richford at East Kent, I discovered that CQC had internally reviewed its actions but had given no public account of this.

I believe that for there to be public confidence in CQC, there needs to be transparency about how well CQC's systems are working, what is wrong with them, and what has been and will be done to improve performance.

I have asked the CQC for information arising from Sally Lewis' case as per correspondence forwarded below.

I hope the committee will help ensure that CQC protects the public more effectively.

With best wishes and thanks,

Dr Minh Alexander

Cc Public Accounts Committee

From: REDACTED
To: Ian Trenholm <ian.trenholm@cqc.org.uk>
Cc: REDACTED
Sent: Thursday, 1 June 2023 at 23:21:54 BST
Subject: Audit of CQC's application of Regulation 12 and failure by CQC to prosecute within legal time limits in the case of Sally Lewis

BY EMAIL

Ian Trenholm
Chief Executive
Care Quality Commission

1 June 2023

Dear Mr Trenholm,

Audit of CQC's application of Regulation 12 and failure by CQC to prosecute within legal time limits in the case of Sally Lewis

I previously wrote to the CQC about the CQC's original advice to baby Harry Richford's family (East Kent maternity scandal) that it could not prosecute under

CQC Regulation 12, when in fact there was evidence of organisational failure which warranted prosecution.

I also wrote again on 21 May 2023 to ask if CQC should be investigating University Hospitals Birmingham NHS Foundation Trust under Regulation 12, I provided evidence of repeated organisational failings and a linked pattern of "severe" and "catastrophic" patient harm from the trust's own documents. I await CQC's response to this enquiry.

These two sets of correspondence are forwarded below and attached.

I now write to ask for information about the CQC's delay in mounting a prosecution under Regulation 12 over the avoidable death of Sally Inquest, at The Dock, a facility run by the care company Dimensions UK on 27 October 2017.

An internal investigation by Dimensions UK in December 2017 reportedly concluded that medication audits which should have identified that Sally Lewis was not receiving laxative medication were not taking place, and that the organisation had failed to ensure that staff knew how to conduct such audits.

A external safeguarding investigation by the local authority which commenced in early 2018 concluded there were deficiencies in senior management oversight at Dimensions that contributed to the medication and care failures.

The inquest into Sally's death at the end of May 2023 has now confirmed that there were organisational failings which contributed to Sally Lewis' death. The coroner determined that these failings were so serious that they amounted to neglect.

All this evidence brings these matters firmly into the ambit of CQC Regulation 12 and within CQC's investigative and prosecutorial powers.

CQC would have been automatically notified of Sally Lewis' death at the time that it occurred in 2017, under the statutory notification provisions. But CQC did not mount a prosecution until 2020.

This is despite being under an obligation to mount a prosecution within a year of coming into possession of sufficient evidence of an offence, and not more than three years after an offence occurs.

It was reported in evidence to the recent inquest that a post mortem on 31 October 2017 found that Sally had gross faecal impaction and bowel necrosis.

It was also reported that the CQC conducted an inspection of Dimensions UK services in November 2017 specifically in response to concerns raised by Sally's death.

CQC was then reportedly further alerted to Safeguarding concerns by the local authority in January 2018, specifically arising from Sally's death.

Sally Lewis' death by constipation with severe bowel obstruction was a clear cut case in terms of cause of death and the link with a failure of care.

It is hard to understand why a prosecution was not quickly brought.

Please could CQC provide the following information:

1) On what date did CQC receive the statutory death notification from Dimensions UK about Sally Lewis' death?

2) In response to the death notification, what enquiries, if any, did CQC make to Dimensions UK about the death and what information did CQC ascertain about the death?

3) Was any CQC inspection(s) of the Dimensions UK facility, The Dock, where Sally Lewis died, carried out after her death?

The published record of CQC inspections on The Dock appears to only go up to 2014:

https://www.cqc.org.uk/location/1-352276223/reports

If any inspections of The Dock were carried out after Sally Lewis' death, please disclose copies of the reports and or summary information held about the findings of these inspections.

4) What action did CQC take after receiving the Safeguarding alert about Sally Lewis's case from the local authority in January 2018, in terms of:

a) Protecting other people in Dimensions UK's care, especially people at risk of constipation

b) Assessing whether a CQC Regulation 12 investigation of care failings by Dimensions UK was indicated by Sally Lewis' case?

5) At what point did CQC avail itself of:

- The October 2017 post mortem findings
- The Dimensions UK November 2017 internal investigation report
- The 2018 local authority Safeguarding review report

6) What was the highest level of CQC management at which were any decisions to investigate and prosecute under Regulation 12 made regarding Sally Lewis' death?

7) Has CQC conducted any review of its handling of the Regulation 12 issues in Sally Lewis' case, and why it took so long to bring a prosecution? If so, please share a copy of the relevant report and or at least a summary of the findings.

8) Given that there has been more than one controversy about CQC's handling of its duties under Regulation 12, has CQC undertaken any wider audit/ review of

its general application of Regulation 12? If so, indicated when this took place and please share a copy of the relevant report. If no such audit/ review has been undertaken, are there any plans for such audit/ review?

Many thanks.

Yours sincerely,

Dr Minh Alexander

Cc

Ian Dilks CQC Chair
Parliamentary Health and Social Care Committee

(1) CORRESPONDENCE TO CQC ABOUT APPLICATION OF CQC REGULATION 12 AT UHB IN RELATION TO RECURRENT ORGANISATIONAL FAILURES RESULTING IN SEVERE AND CATASTROPHIC HARM FROM FALLS

From: REDACTED
Subject: Organisational, systemic care failures by UHB and Regulation 12 matters
Date: 21 May 2023 at 12:30:09 BST
To: REDACTED
Cc: REDACTED

BY EMAIL

Sean O'Kelly
CQC Chief Inspector of Hospitals

21 May 2023

Dear Sean,

Organisational, systemic care failures by University Hospitals Birmingham NHS Foundation Trust and CQC Regulation 12 matters

I write to forward a coroner's Prevention of Future death report of 19 May 2023 on Ms Norma Bruton who died aged 77 after an unwitnessed fail at University Hospitals Birmingham NHS Foundation Trust (UHB) on 22 October 2022. She fractured her neck of femur during the fall and did not survive surgery.

https://minhalexander.files.wordpress.com/2023/05/uhb-norma-bruton-prevention-of-future-deaths-report-2023-0165_published.pdf

The coroner criticised a flaw in UHB's falls risk assessment process.

You will be aware that CQC issued one of UHB's hospitals with a warning notice in December 2022 for unsafe staffing levels that contributed to avoidable harm and falls, some of which actually happened live during that inspection.

Trust papers show that inpatient falls regularly result in severe and catastrophic harm - see page 6:

https://minhalexander.files.wordpress.com/2023/04/lisa-stalley-green-uhb-2020-falls-bod0420carequalityreport.pdf

Should the CQC be investigating UHB under CQC Regulation 12 for systemic, organisational failures to provide safe care?

Best wishes,

Minh

Dr Minh Alexander

Cc

Ian Trenholm CQC CEO
Ian Dilks CQC Chair
BBC Newsnight

(2) CORRESPONDENCE ABOUT CQC'S APPLICATION OF REGULATION 12 IN BABY HARRY RICHFORD'S CASE AT EAST KENT

From: REDACTED
To: REDACTED
Cc: REDACTED
Sent: Thursday, 24 November 2022 at 13:45:09 GMT
Subject: REDACTED

Dear Dr Alexander,

Please find attached a letter from Carolyn Jenkinson, Head of Hospital Inspection in the South Network at the Care Quality Commission.

Thank you for writing to us.

Kind regards

Terezia Novosel

Care Quality Commission

Terezia Novosel (Temple Quay House, 2 The Square, Bristol BS1 6PN)

Team PA Deanna Westwood - Director of Operations South Network and the South Network Heads of Inspection.

From: REDACTED
To: REDACTED
Sent: Wednesday, 12 October 2022 at 10:33:17 BST
Subject: Harry Richford's death - CQC Regulation 12 and CQC's position on organisational failures by EKUH

Dear Sir,

Harry Richford's death - CQC Regulation 12 and CQC's position on organisational failures by East Kent University Hospitals NHS Foundation Trust

Please could the CQC comment on why Emma Carroll CQC inspector wrote to Harry Richford's family on 17 August 2018 to tell them that CQC had reviewed Harry's case and believed that there were failures by individuals and not the trust? She wrote:

"After an extensive review, we do not believe there has been a breach in regulation. The concerns raised in this incident are centred on an individual's decision or error. The criminal offences CQC can prosecute against only apply to registered person failures. I understand from your emails, the GMC are using their powers to investigate this.

The actions taken by the trust to date, in line with the recommendations by the independent reviews, suggest the previous risks have been mitigated. Evidence for this include the introduction of safety huddles, a consultant handover form, additional staff training, improved recruitment processes and new guidance on difficult intubation."

Also, please comment on why Ted Baker wrote to the family on 25 September 2018 to imply that there were no grounds for prosecution under Regulation 12. He wrote:

"I want to assure you that, although at this stage we have not taken any action relating to a breach of Regulation 12 in the case of your grandson, we are continuing our investigation as further information becomes available."

Clearly there were Regulation 12 issues, because CQC went on to announce a prosecution against EKUH in 2020, under Regulation 12, for harm caused to Harry and his mother Sarah.

Does CQC believe it has adequately explored why it initially failed to identify - or acknowledge - organisational failings by EKUH?

Would the CQC like to comment on what materially changed, to alter the CQC's position on the prosecution of EKUH for harm done to Harry Richford and his mother?

Would CQC comment on the fact that it later confirmed to the media that it had seen the trust's action plan from a 2015 RCOG review which identified risks, but did not actually see the report itself until 2019, after the Richfords discovered the report and pointed it out to the CQC?

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?

Thanks

Minh

Dr MInh Alexander