



Memorandum of Understanding between the Coroners' Society of England and Wales and the Care Quality Commission

Introduction

1. This Memorandum of Understanding ('MoU') records an agreement between the Coroners' Society of England and Wales and the Care Quality Commission ('CQC'). It is intended to promote and continue effective working relationships between Coroners and the Care Quality Commission.

Nature of the agreement

2. This MoU describes a voluntary agreement. The parties to it recognise that Coroners are independent judicial officers. The agreement is not binding and is not intended to create legally enforceable rights, obligations or restrictions.

Aims

3. To promote consistency, with the intention that this will allow Coroners and CQC to discharge their different and independent statutory functions and use their limited resources to best effect.
4. To set out clearly the level of assistance that the CQC can legitimately provide to the Coroner following a death in a registered social or healthcare care setting.
5. To promote the wider public interest of holding effective inquests into deaths in a registered health or social care setting without prejudicing ongoing criminal proceedings or enforcement actions.

The Care Quality Commission (CQC)

6. CQC is the independent regulator of health and social care in England. It is also the lead inspection and enforcement body under the Health and Social Care Act 2008 (HSCA 2008') for the safety and quality of health and social care services provided to patients and other service users by providers registered with CQC.

7. CQC's regulatory remit includes

- Care and nursing homes
- Private and public hospitals
- Health and social care in secure settings including prisons, youth offender institutions and secure hospitals.
- Domiciliary care
- GP and dental practices and
- Mental health services.

8. CQC's main objective is to protect and promote the health, safety and welfare of people who use health and social care services, as set out in the HSCA 2008, and its associated regulations, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('RAR 2014') and the Care Quality Commission (Registration) Regulations 2009 (RR 2009).

9. All registered providers are under a legal duty under the RR 2009 to notify CQC of the death of a user of the service where the death has occurred during the carrying on of a regulated activity or where the death may have resulted from a regulated activity. This includes any patient who at the time of death is detained or liable to be detained under the Mental Health Act 1983.

10. CQC will pursue civil and, where appropriate, criminal enforcement action against registered providers of health and social care services for breaches of health and social care law under HSCA 2008 and RAR 2014.

11. From 1 April 2015 CQC has a power to prosecute registered providers for failures to provide safe care and treatment resulting in avoidable harm or a significant risk of exposure to avoidable harm (Regulation 12(1) RAR 2014). The CQC cannot investigate or prosecute murder, manslaughter, health and safety at work act offences, wilful-neglect or ill-treatment.

12. CQC also conducts inspections of registered services and publishes inspection reports. These reports can be found at www.cqc.org.uk.
13. CQC also has a duty under s.120 of the Mental Health Act 1983 to keep under review the exercise of powers and discharge of duties conferred or imposed under that Act in relation to patients who are detained or otherwise subject to the Act's powers.
14. A Memorandum of Understanding between CQC, the Health and Safety Executive and Local Authorities outlines in greater detail enforcement responsibilities for fatalities in a health and social care setting post 1 April 2015.
15. CQC has limited resources with which to meet its core responsibilities, functions and strategic priorities. Any assistance to the Coroner is incidental to, and not a part of, CQC's statutory functions

The Coroner

16. The Coroner alone is responsible for deciding the scope or ambit of the inquest. The Coroner must ensure that the relevant facts are fully and fairly investigated and are the subject of public scrutiny during the inquest hearing. The wider public interest also serves the need to ensure that the risk of prejudice to any ongoing investigation and potential criminal proceedings is minimised.
17. The Coroner may request assistance from CQC. CQC will assist a Coroner wherever possible. This agreement recognises that such assistance is incidental to, and not part of, CQC's function. The statutory responsibility for ascertaining the identity of the deceased, and when, where and how they came by their death, remains with the Coroner. CQC can only pursue civil and enforcement actions within the authority granted by the HSCA 2008.

Enquiries undertaken by CQC

18. CQC's response to a death will depend upon a number of factors. In some cases CQC will gather evidence about the circumstances of the death including taking witness statements from relevant individuals. In other cases CQC will conduct an inspection to gather evidence about the death and ongoing risks and compliance with the Regulations.
19. From 1 April 2015 CQC has the power to prosecute registered providers for failures to provide safe care and treatment where the failure results in avoidable harm or an exposure to a significant risk of avoidable harm. For failures occurring before 1 April 2015 CQC's powers are restricted.
20. CQC's offences are summary only and proceedings must be brought within 12 months of the date the prosecutor had sufficient knowledge to warrant proceedings being brought, and in any event within three years.
21. Where CQC gathers or holds evidence about the circumstances of the death or the quality of treatment or care the deceased received this evidence will be shared with the Coroner. Where criminal enforcement is being considered by CQC the Coroner will consult with CQC about disclosure of material before disclosing to other interested persons.
22. CQC agrees that Coroners and/or their officials need to be kept informed of the progress of its criminal investigations. CQC will, therefore, regularly keep the Coroner informed as to progress of their investigation and discuss issues arising from the investigation that may impact on the coronial investigation.
23. The parties to this MoU recognise that CQC investigations are restricted by HSCA 2008. Coroners will not attempt to direct CQC's criminal investigations. Where possible there should be an early discussion between CQC and the Coroner in cases where CQC is the lead enforcement body.

24. Those early discussions should deal with matters such as likely timescales for the investigation; timing of any inquest; chronology of any legal proceedings; and how and when future updates will be provided. This will enable the Coroner to pursue any separate lines of enquiry, or to take additional statements, that they consider necessary for their inquest.

Reports to the Coroner

25. CQC acknowledges that, in some cases, the Coroner may be assisted by the preparation of a report summarising CQC's enquiries. The Coroner recognises that this will not be necessary for every death in a health and social care setting.

26. Where such a report is requested the report will be a concise summary of the nature of the enquiries made, witnesses spoken to and timescales for enforcement action including a prosecution decision. In many cases the Coroner will be better assisted by CQC sharing evidence gathered or held.

Chronology of proceedings

27. If CQC decides not to prosecute it will notify the Coroner of its decision.

28. If CQC decides to prosecute, it will consider in each case whether to commence those proceedings before or after any inquest. In making this decision, CQC will take into account a number of factors including:

- When any inquest could be held.
- The views of, where applicable, the Coroner, police, HSE, Local Authorities, CPS and the bereaved family members.
- Whether any further information may come to light as a result of the coronial investigation and inquest.

- The statutory time limit for CQC offences.
- The nature of a potential defendant (individuals or corporate bodies).
- Any risk of prejudice to future criminal proceedings.

29. In cases where CQC intends to prosecute before the inquest has concluded CQC will consider asking the Coroner to exercise his or her discretion to adjourn the inquest. Each case will be assessed on its individual merits.

Notification of Inquests

30. The Coroner agrees to notify CQC as soon as is reasonably practicable of any inquest where concerns exist about the care or treatment received by the deceased. This includes deaths in secure settings and detained patient deaths.

31. Notifications should be made to CQCInquestsandCoroners1@cqc.org.uk. This notification should, whenever practicable, include the deceased's name, date of birth, the registered provider's name and address, brief details of the immediate circumstances and any other relevant information as determined by the Coroner.

Assistance to the Coroner

32. Where the Coroner requires assistance from CQC the Coroner agrees to specify the nature of the assistance required (documentary or witness evidence). For example a Coroner may decide to limit a request to information about recent inspections or compliance or limit assistance to a specific issue or time period. This approach will enable CQC to focus its response and more effectively assist the Coroner.

Regulation 28 reports

33. The Coroner agrees to provide CQC with copies of any Regulation 28 report and response where concerns about care or treatment provided by a registered provider have been identified during or at the conclusion of the inquest. This includes Regulation 28 Reports following deaths in secure settings and deaths of detained patients.
34. These reports will enable CQC to more effectively discharge its statutory functions and in particular to meet recommendation 282 of the Francis Report. The Coroner agrees to provide these reports and the responses thereto as soon as reasonably practicable to the following email address: CQCInquestsandCoroners1@cqc.org.uk.
35. Where the Coroner requires CQC to respond to a Prevention of Future Death report pursuant to paragraph 7 Schedule 5 of the Coroners and Justice Act 2009 these reports should be sent to: CQCInquestsandCoroners1@cqc.org.uk.