Dr Peter Harrowing
HM Assistant Coroner
The Coroner Court
The Court House
Old Weston Road
Flax Bourton
BS48 1UL

Dear Dr Harrowing,

Re Kimberley Parsons (Ref: 01019/2014)

I am writing following your recent letter, dated 4 March 2015, and the attached 'Regulation 28: Prevention of Future Death Reports'.

You may be aware that the Care Quality Commission (CQC) carried out a comprehensive inspection of the Avon and Wiltshire Partnership NHS Trust (AWP) in June 2014. This was one of the 'pilot' new style comprehensive inspections of NHS and independent healthcare organisations. As such, whist we provided a narrative in the report as to whether the trust was providing safe, effective care that was responsive to people's needs, delivered by staff that were caring and whether the trust was well led we did not provide a rating (we now rate organisations on a four point scale – outstanding, good, requires improvement and inadequate against these key areas). During our inspection of AWP, our inspection team, made up of experienced specialist advisors, experts by experience (people with experience of using services or caring for someone using services) and CQC staff, we visited all in-patient wards and a sample of community mental health services.

As a consequence of the inspection enforcement action was taken and four warning notices were issued. The warning notices served to notify the provider (AWP) that CQC had judged that the quality of health care provided for the regulated activities required significant improvement. Two of the warning notices were relevant to Hillview.

Firstly, a trust wide warning notice was issued regarding learning from incidents, Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This warning notice highlighted the trust's failure to respond to an inspection undertaken in March 2014.

Secondly, a warning notice, specific to Hillview Lodge, was issued under under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 15. This identified that:

- The ward did not meet the required level of cleanliness and the design and decoration of the ward did not support a therapeutic environment;
- Potential ligature risks that had not been effectively mitigated or managed;
- The garden was not well maintained and contained overgrown trees and shrubs that may have posed a ligature risk or a means of escape;
- Shower and bathroom facilities were in a poor state of repair;

- Areas of the ward and grounds were staff could not easily observe patients; and
- The design of the unit did not promote privacy or dignity.

Additionally, a number of compliance actions were issued; four were relevant to Hillview. The compliance actions served to inform a AWP that it was not compliant with the regulations. These included:-

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 9 (1) – observation practice.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 16 (1)(b) – emergency equipment.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 10 – learning from incident.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 23 – training.

CQC maintained regular contact with AWP following the comprehensive inspection in order to monitor progress its progress in meeting requirements and in addition, in December 2014 carried out a programme of unannounced inspections across AWP to establish whether the trust had complied with the warning notices.

We carried out a focussed inspection at Hillview on the 17 December 2014. This identified:

- Significant financial investment had be made to improve the lines of site., For example, wall had been knocked down to open up an area thus provided improved observation of patients
- The ward was clean;
- Observations were being carried out in line with risk assessments;
- Significant investment in both finance and time had been undertaken to identifying ligature points across the ward resulting in a complete 'Manchester Tool' ligature assessment. Plans were in place to rectify or manage the risks from existing ligatures. For example, a tree involved in a fatal injury in the garden area had been cut down.

Therefore, CQC judged that AWP had taken all reasonably practicable steps, within the time frame given, to comply with the relevant two warning notices.

However, the compliance actions remain in place. AWP is not yet fully compliant. For example, not all ligature risk management processes had been completed.

As the inspection in June 2014 was part of the 'pilot' programme and not rated a further comprehensive inspection will be undertaken at some time in the future (before April 2016) when AWP will be rated. As part of the inspection Hillview Lodge will be visited and particular attention will be paid to progress made against the compliance actions.

In addition, CQC undertakes focused visits to assess compliance with the the Mental Health Act. Whilst these visits look closely at issues surrounding patients detained under the Mental Health Act they also look at environmental issues and health and safety. An unannounced Mental Health Act visit will be made to Hillview Lodge in the next few months.

Thank you for sending us a copy of the report that was issued to AWP regarding to the practice of an individual clinician. We have brought this to the attention of [redacted] Executive Director of Nursing at AWP during one of our routine meetings. [redacted] will establish and provide further feedback regarding this. The practice of individual clinicians is not within CQCs remit.

Yours sincerely

[redacted]

Inspection Manager

Cc: [redacted], Executive Director of Nursing (AWP)