HSCA
Citygate

Gallowgate

Newcastle upon Tyne
NE1 4PA

HM Senior Coroner
The Coroner's Court
The Courthouse
Old Weston Road
Flax Bourton
BS48 1UL

3 February 2017

Care Quality Commission (CQC)
Our Reference: [redacted]
Your Reference: [redacted]

[redacted]

Dear HM Coroner

Prevention of future death report following inquest into the death of Mr Martyn Watkins.

Thank you for your letter dated 14 November 2016, enclosing the above Report.

We are also grateful for the extension of time granted for this response (until 6 February 2017).

As you are already aware the Provider which is registered with CQC and has overall responsibility for services provided at the relevant location (Callington Road Hospital) is Avon and Wiltshire NHS Partnership Trust.

CQC became aware of the sad death of Mr Watkins on 16 May 2016, when the Trust shared a management report with us through an online information sharing system. The report had been uploaded to the system on 12 May 2016. This was received by the lead CQC inspector for the Trust.

We noted that Mr Watkins had been detained under Section 2 of the Mental Health Act (MHA). We had not received a statutory notification of a death of a detained patient so we contacted our MHA office in Nottingham to check. Once it was confirmed that we had not received notification we called the MHA Administrator at the Trust to ask why we had not been notified. We were told that Mr Watkins had been discharged from his section on transfer to Southmead Hospital.

At the time we planned to inspect older adults' inpatient services between 16 and 27 May 2016 as part of our comprehensive inspection programme. We asked the

inspector leading the team to follow this up when they visited Aspen Ward. During the inspection we found that the Trust had learnt from the death and implemented changes to manage future risks on Aspen Ward.

However, the rating for the overall core service (older people's mental health inpatient wards) was "requires improvement" because:

- There were not sufficient staff numbers to meet the needs of people using the services. There was a high level of qualified nurse vacancies on some wards with no psychology input.

- Levels of emergency response training and practical patient handling training were low.

- Staff did not consistently adhere to Mental Health Act legislation and standards described in the Mental Health Act (MHA) 1983 code of practice.

- Staff completed mental capacity assessments but did not document decision specific assessments.

- Staff were inconsistent when reporting of incidents.

- Staff did not always follow agreed actions or involve patients in care plans.

- Staff did not all use the health of the nation outcome scales for over 65s. They were not consistently monitoring patient's outcomes.

- Multidisciplinary team meetings did not all have a full range of professions.

- The standard of the environments was variable. They were not all "dementia friendly". Safety alarms were of variable quality or were not available. Some bedroom windows did not protect patient's privacy and some patients slept in dormitories.

Our response to the matters raised in the Regulation 28 letter is as follows:

1. As a regulator CQC has both criminal and civil enforcement powers. There are two primary reasons why we may use our enforcement powers. First to protect people who use regulated services from harm and the risk of harm and to ensure they receive health and social care services of an appropriate standard. Secondly to hold providers to account for failures in how the service is provided.

> Further and more specific detail is included in our published Enforcement Policy, a copy of which is available free of charge on our web-site (http://www.cqc.org.uk/content/enforcement-policy)

2. The civil enforcement powers are aimed at ensuring that any ongoing risk to patients, such as those detailed in the Regulation 28 Report are appropriately identified, and that where risks are still found to exist that we as a regulator take proportionate action to ensure that the Provider becomes compliant with the relevant

legal requirements which ensure patient safety. Such action can be anything from formal 'Requirement Notices' / 'Warning Notices' to imposing urgent conditions on the Registration of a Provider and in extreme circumstances suspending or cancelling the Registration of a Provider.

> In relation to this particular Trust we are exercising our statutory powers to request information and documentation to identify and determine the level of risk to patients. As part of this process we have also already exercised our statutory powers of Inspection (on 10 January 2017) and we are currently liaising with the Trust to ensure that patients are properly protected. The Inspection and the associated regulatory actions are looking at not just the matters identified in the Regulation 28 Report but also wider issues which may impact on safe care and treatment for patients.

3. The criminal enforcement powers which we have are aimed at holding Providers to account where there has, for example, been a failure on the part of a Provider in terms of safe care and treatment, and where those failure(s) have then resulted in avoidable harm to a patient (whether physical or psychological), or alternatively where the failure(s) expose a patient to serious risk of such harm. We do not have regulatory powers to take action against individuals (e.g. clinical / healthcare staff) where there are individual failings (as those would be dealt with by other professional bodies). However this does not mean that we will not look at individual failings to determine why they occurred and specifically consider whether a Provider could/should have taken action to ensure that such failings were avoided altogether.

> In relation to this particular Trust we have noted that the indication from the Trust in the Root Cause Analysis (RCA) Investigation Report (Reference: 2016/8370) appears to be that the sad death of Mr Watkins was caused by an individual failing to remove from his possession a belt. Whilst we are grateful to receive the RCA as well as the 'Management Report on Red Graded Incidents dated 31/03/2016' from the Trust, we are reviewing for ourselves the circumstances which led to the sad death of Mr Watkins and in accordance with our regulatory remit will make our own judgments in that regard.

We are happy to keep HM Coroner updated on the progress of our regulatory actions should HM Coroner deem this to be appropriate.

Should you require any further information please do not hesitate to contact us:

By email: HSCAfurtherinformation@cqc.org.uk
Cc'd to: [redacted]

By post: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please include the reference number MRR1-3078722466 on all correspondence.

Thank you in advance for your assistance.

Yours sincerely

[redacted]
Head of Inspection Hospitals (Mental Health South Central)