Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Mr P C Spinney
Area Coroner for South Wales Central
The Coroner's Court
Central Police Station
Cathay's park
Cardiff
CF10 3NN

January 2018

Dear Mr Spinney

Regulation 28 Report to Prevent Future Deaths – Stephanie Monica Cave

Thank you for your letter enclosing your Regulation 28 report following your investigation into the death of Stephanie Monica Cave.

You will wish to be aware that Healthcare Inspectorate Wales (HIW) completed an unannounced focussed inspection of Heatherwood Court on 24 and 25 September 2017. The purpose of the visit was to assess whether Heatherwood Court Hospital is appropriately managing risk, specifically in relation to self harm and suicide. This inspection was in response to HIW being notified of the death of a detained patient (Stephanie Monica Cave).

As with your investigation, HIW raised a number of concerns in regards to the observation of patients detained under the mental health act. In response to HIW's concerns Heatherwood Court provided an implementation plan of actions they have taken/would take. These actions included –

- A review of training materials and an update to enhanced observation practice.
- An amendment to observation recording sheets to explain to staff what action is required in relation to the patients required level of observation.

In addition the NHS Wales Quality Assurance Improvement Team (QAIT) undertook an immediate assessment of the clinical observation procedure within the hospital through an unannounced inspection on 9 January 2018. QAIT were informed of concerns raised through your Regulation 28 report and deployed clinical members to assess the site.

Concerns were again raised in relation to observations which included gaps in observation and enhanced observation records and the sign off of day shift forms which highlight any action required/completed addressed. QAIT will continue to work with the provider to ensure these concerns are addressed and appropriate action is taken.

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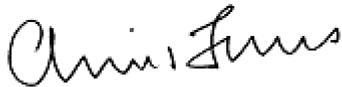
The statutory Code of Practice (for Wales) 2016 to the Mental Health Act 1983 sets out specific guidance in relation to the practice of clinical observation given in chapter 26 and applies to Independent as well as NHS mental health hospitals/units in Wales. The overarching clinical imperative is that there should be a clear local policy on the clinical observation of patients as an integral aspect of patient engagement and the assessment and management of safety concerns. The Code addresses specific points of relevance to the matters of concern you raise regarding the process of conducting and recording the clinical observation of patients and staff training. In addition, the Code references relevant guidance issued by the National Institute of Clinical Excellence's (NICE).

We have sent copies of the Code of Practice on the Mental Health Act to the Operational Manager of Heatherwood Court and all units in Wales under the management of Ludlow Street Healthcare.

I hope you find this response helpful.

Yours sincerely



PROFESSOR CHRIS JONES