South West London and
St George's Mental Health
NHS Trust

Chief Executive's Office
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Springfield University Hospital
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03 June 2026

**Private & Confidential**

Richard Furniss
Assistant Coroner for South London
25 Bagleys Lane
Fulham
SW6 2QA

[redacted]

Dear Sir,

**Re: Regulation 28 Report to Prevent Future Deaths – Lajos Mandrik**

On behalf of South West London and St George's Mental Health NHS Trust, I wish first to express our sincere and unreserved condolences to the family of Mr Lajos Mandrik. We recognise the profound impact of his death and the importance of responding fully, transparently, and with urgency to the concerns identified at inquest.

We are grateful for the matters raised in your Regulation 28 Report dated 1 April 2026, and we accept the findings made. We are committed to ensuring that the learning from this case results in sustained and measurable improvements in care.

In order to examine all of the concerns raised, the Prevention of Future Death Report was shared with the clinical leadership team responsible for Mr Mandrik's care and treatment and our Trust board quality committee to ensure a thorough organisational response and appropriate oversight.

We acknowledge the serious concerns raised regarding observation and engagement and the importance of ensuring that observation practices are safe, therapeutic, and compliant with Trust policy at all times. As you are aware the Trust made immediate changes post the death of Mr Mandrik and has continued to work on improving compliance with Observation and Engagement through daily checks of completion by

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the Nurse in Charge as well as weekly assurance Audits. There was continuous work done on revising the policy and adjustments made in line with the existing training package to include an agreed code of conduct that clearly lays out expectation on roles and responsibility by staff who undertake observation.

In September 2024, NHS England launched the Enhanced Therapeutic Observation and Care (ETOC) programme, which supports trusts to make local, clinically led, and patient centred approaches that improve their care provision.

The Trust joined cohort 2 of this project in May 2025 and began working on a number workstreams from September 2025, across all three-service line inpatient wards. The focus of this work was on improving compliance with observation as well as to revise current Trust Policy.

In October 2025 as part of the ETOC project the Trust began a comprehensive review of the Observation and Engagement Policy to provide greater clarity regarding expectations for all levels of observation.

Following receipt of your Regulation 28 report, the Trust conducted a structured Walkthrough under the Patient Safety Incident Response Framework (PSIRF). This exercise mapped the processes and workflow associated with observation practices, identifying the gap between "work as imagined" (policy) and "work as done" (practice). This has enabled us to identify operational pressures, variations in staff understanding, and inconsistencies in application. Findings from this review have also directly informed the policy revision and identified further improvement actions.

I therefore provide a response to your concerns and direction as they were raised in your correspondence:

*The MATTERS OF CONCERN are as follows:*

1. *'The Trust's policy - in common with that of other Trusts - is that all observations should include an attempt, at least, at engagement. The written logs of observations suggest that, most of the time, no attempt is made at engagement during observations, in September 2023 or now. Intermittent observations may be recorded as, for example, 'Corridor - pacing' because the HCA has seen the patient but not attempted to engage with the patient. General observations, once per hour, appear to be no more than a headcount to make sure all patients are present on the ward (then and now).*

1. **Trust Policy – Clarification of the observation model**

The Trust has undertaken a comprehensive review of the Observation and Engagement Policy in line with NICE guidelines with an increased focus on quality of observations to improve patient's experience as well as to provide greater clarity regarding expectations for all levels of observation. Specifically, the revised policy outlines the expectation for staff carrying out General and Intermittent Observation stating: General observations are the baseline observation applied within the trust, these low-level observations are performed hourly with the intention of locating a patient and visually checking their wellbeing. Intermittent observation is intended to be used for patients who are potentially but not immediately at risk of seriously harming themselves or others, or there are concerns about their physical health which requires them to be monitored and supported at specific times through a well-being check and supported with a meaningful engagement.

The governance process to support implementation of the revised policy will ensure a smooth transition for the implementation and the actions are as follows:

- The revised policy was presented in the Quality Governance Group in May 2026, this will be ratified at the June 2026 meeting.
- Webinars are scheduled for the launching of the policy from July through to September. This is across all inpatient services and includes both substantive and bank/agency staff.
- The e-learning package has been updated to include the changes made in the policy and all staff will be expected to compete this with a new competency framework to demonstrate understanding and compliance with Observation. This will be reviewed by 30 December 2026 to ensure staff are compliant

The Trust has an existing digital system that supports recording Constant and Enhanced Observation. To improve consistency, transparency and auditability of observations, the Trust will move general and intermittent observations to the same digital format. To enable this process, there is a plan to pilot the use of digital technology, 'e-obs' in 6 inpatient wards across the organisation, to ensure a collaborative approach to change in practice. This digital system will support a more detailed documentation which will include a safety and wellbeing check on patients during both general and intermittent observation. A set of PDSA cycles will be undertaken to ensure the change is supported and understood by staff. With a final evaluation of the pilot completed by 31 July 2026, with a planned phased roll-out across all inpatient wards by 31 October 2026, subject to evaluation findings.

In addition, a new credit card sized memory Card has been created as an aid-memoir that can be kept on staff's lanyard that will support staff at a glance to

differentiate between each level of observation as well as a minimum expectation of engagement under each observation level.

*The MATTERS OF CONCERN are as follows*

*2. This impression, gleaned from the documentation, appeared to be confirmed by the oral evidence of HCAs at the inquest. It appears that the general and intermittent observations on Ellis Ward are not being carried out in accordance with the Trust's policy. If this was and remains the culture on Ellis Ward, it may also be the culture on other wards operated by the Trust (since some staff work on more than one Trust ward).*

We acknowledge that HCAs were specifically referenced in HM Coroner's concerns and recognising that sustainable improvement requires cultural as well as procedural change, the Trust is implementing a programme of workforce development for all disciplines across all inpatient wards including:

- Mandatory competency-based assessment for all staff across the organisation undertaking observations; and
- Reinforcement of roles, responsibilities and expectations through training as well as monitoring through regular supervision.

We will also increase visibility of leadership by regular ward visits to support staff in safe management of patients on observation and better oversight on whether the Observation Policy is being followed by staff. This oversight will:

- Strengthen quality of engagement (not just compliance);
- Track patient experience and outcomes (e.g. reduction in incidents, improved feedback); and
- Reduce prolonged restrictive practice via robust step-down planning.

The Trust also has a Nursing Optimisation & Workforce Programme that is focusing on compliance with observation and the quality of these. Having learned from the death of Mr Mandrik, the programme has reviewed the quality of observations and aims to ensure that all observations are supportive of the patient and are a therapeutic intervention. A dashboard to understand the quality of observation is being created and aim to be in use and visible to clinical staff in June 2026.

Delivery of these actions will be overseen through the Trust's established governance structures, including the Board Quality Committee. This programme of work is designed not only to address the specific concerns highlighted in your report, but to ensure sustained improvement in patient safety, therapeutic engagement, and quality of care across all inpatient services.

Formal review will be undertaken in June 2027 to evaluate the implementation plan, and whether there has been an improvement in practice in line with observation.

On behalf of the Trust, I extend my deepest and sincerest condolences to Mr Mandrik's family. We are committed to learning from this tragic event and to implementing the necessary improvements to reduce the risk of future harm.

We will continue to monitor the effectiveness of these actions and ensure that they are embedded into routine practice.

Please do not hesitate to contact me should you require any further information.

Yours faithfully,

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**Chief Executive**

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