Department of Health

From Norman Lamb MP
Minister of State for Care and Support

Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Mr I Smith
Senior Coroner
Central Police Station
Market Street
Barrow-in-Furness
Cumbria
LA14 2LE

02 SEP 2014

Dear Mr Smith,

Thank you for your letter following the inquest into the death of James Boylan. I am replying as the Minister responsible for Mental Health.

In your report you conclude that the cause of death was hanging. Mr Boylan died as a consequence of his own actions while suffering from mental illness. You found that Mr Boylan suffered from chronic anxiety, for which he had received counselling from MIND and a psychiatrist. He had had multiple GP appointments. In July 2013 he was admitted to a special mental health unit at Furness General Hospital. Within a few days he hanged himself using a phone charger cord, from a rail in a bathroom designed for use by disabled patients.

You raise the following concerns:

- There were removable bathroom rails in a bathroom designed for use by disabled people. These bathroom rails had not been removed and so provided a ligature point in a unit designed to have as few ligature points as possible. You are concerned this situation may exist in other units and want ligature points in mental health units to be limited as far as possible;

- Mr Boylan had brought a Stanley knife blade onto the ward which was not discovered for several days. The origin of the phone cord Mr Boylan used to hang himself is also unclear. You ask both for a more robust approach in searching patient property and that the policy of having dangerous items held centrally is followed;

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- During the seven days Mr Boylan was on the ward there were signs his condition was escalating and that he might become a danger to himself but no-one appeared to have overall knowledge of all the facts. You suggest that communication is improved by the Trust;

- Patient assessments should be more rigorously completed and disseminated to staff.

In addition, in your covering letter, you point out that in Cumbria alone in a ten month period from April 2013 to January 2014, twenty people, who had been in touch with mental health services within the previous week, died by suicide. You enclose a document from Cumbria CCG provided in response to another Regulation 28 case. This quotes a report by the Royal College of Psychiatrists in which it is reported that a similar pattern, ie of people who have been seen by mental health staff in the previous week dying by suicide, is being seen nationally. You draw our attention to this and consider it a matter of grave public concern.

I note that you have also addressed your report to the Cumbria Partnership NHS Foundation Trust and I would expect them to properly address the four concerns relating to events during Mr Boylan's time on the Dova Unit at Furness General Hospital.

It is of course a matter of great concern to me that suicides are occurring despite patients' recent contact with mental health services. It may help if I provide some information about our current and future suicide prevention work.

The NHS Outcomes Framework sets out the outcomes and corresponding indicators used by the Government to hold NHS England to account for improvements in health outcomes. It remains a high priority for us to ensure that NHS England learns from all incidents and reduces premature deaths. This happens in a number of ways.

All reported incidents, such as the one you outline in your report, are reviewed and used to inform future learning. The National Reporting Learning System (NRLS) is used by the NHS to handle patient safety incidents. NHS England uses collated information to help NHS services learn from mistakes or potential incidents. Incidents related to mental health are reviewed by NHS England's

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patient safety team personnel and key learning points are identified. This learning is then used to assist in the design of resources which seek to prevent suicides.

NHS England has used this learning to introduce a variety of resources designed to help clinical staff appreciate the importance of risk assessment and multidisciplinary working in the field of mental health. They have developed audit tools for both inpatient and community care use so that a local trust can measure compliance against these standards.

These are available from the following website at:

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=65297

NHS England has more recently developed further suicide prevention measures and is working with the NHS Confederation to ensure the impact of these are as wide as possible. More details are available from the website address given:

http://www.nhsconfed.org/Publications/briefings/Pages/Preventing-suicide.aspx

From April 2010, serious incidents (i.e. incidents that result in severe harm or death) reported by English NHS trusts to the NRLS have been shared with the Care Quality Commission (CQC) as required by the Care Quality Commission (Registration) Regulations 2009 (Regulation 16). From April 2013 all incidents that are reported to the NRLS have been directly shared with the CQC.

All suicides of people in contact with secondary mental health services in the year prior to their death are reviewed in detail by the National Confidential Inquiry into Suicide and Homicide by people with mental illness (NCISH) – the most recent annual report can be accessed from the following link:

http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/Annualreport2014.pdf

NHS England and NCISH are part of the National Suicide Prevention Strategy Advisory Group. Chaired by Professor Louis Appleby, who also heads NCISH, the group provides leadership and support in ensuring successful

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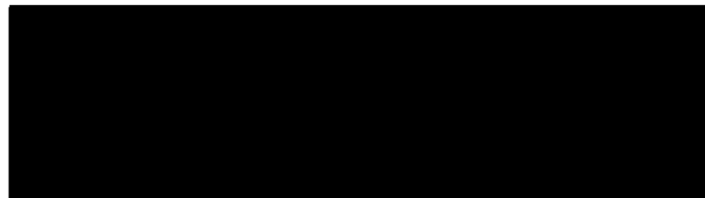
implementation of the Government's suicide prevention strategy for England. It advises the Department of Health, and where relevant other Government Departments and organisations, on the relevance of emerging issues for the suicide prevention strategy and reviews potential changes to priorities and areas for action.

NHS England has identified the need for both a Mental Health Patient Safety Expert Group and an Expert Safety Primary Care Group to improve safety of patients in NHS funded care further. These groups have been established by NHS England to provide senior clinical advice to the NHS commissioning system, support NHS England priorities in patient safety, and lead on the development and dissemination of advice and guidance for both commissioners and providers.

Membership of these groups is multi-professional and includes representation from all sectors of the health community. This helps to foster a positive approach to mental health and wellbeing in every aspect of healthcare delivery.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Mr Boylan's death to my attention.

Yours sincerely,



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