Department of Health & Social Care

From Nadine Dorries MP
Parliamentary Under Secretary of State for Mental Health,
Suicide Prevention and Patient Safety

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Your Ref: JSP/HK/R-Henry
Our Ref: PFD-1187214

Professor John Pollard
HM Assistant Coroner, Manchester West
HM Coroner's Court
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21 October 2019

Dear John,

Thank you for your correspondence of 1 August to Matt Hancock about the death of Ms Rebecca Louise Henry. I am replying as Minister with responsibility for Mental Health and I am grateful for the additional time in which to do so.

Firstly, I would like to say how sorry I was to read of the particular circumstances of Ms Henry's death. I can appreciate how devastating this must be for her family and loved ones and offer my most heartfelt condolences to them.

I note that in this case the Greater Manchester Mental Health NHS Foundation Trust fully accepted your findings and acknowledged that the standard of care provided to Ms Henry fell short of what she should have received. I very much welcome the steps taken by the Trust to put this right and reduce the chance of this situation from happening again, including by putting staff through new risk assessment training and providing them with new advice on how to deal with similar situations.

Your report raises concerns about patient confidentiality and how this can impact on communication between mental health professionals and family and carers where information sharing might help inform decision making about an individual's care.

I am aware that a number of families bereaved by suicide have encountered issues around confidentiality in their interactions with healthcare services. This includes concerns that healthcare practitioners can seem reluctant to listen to information or insights from families and friends, or to give them information about a loved one's

risk of suicide. Prevention of future deaths reports issued by coroners following inquests into suicides share similarities with these concerns and therefore those you have raised in your report.

The Suicide Prevention Strategy for England[1], published in 2012, placed a new emphasis on providing better support to those bereaved or affected by suicide. As part of this, the Department of Health worked with a range of professional bodies to agree a consensus view on confidentiality and suicide prevention. *Information sharing and suicide prevention: Consensus statement'*[2], was published in 2014, alongside the first annual report of the suicide prevention strategy. The statement includes the following passage:

> *We strongly support working closely with families. Obtaining information from and listening to the concerns of families are key factors in determining risk. We recognise however that some people do not wish to share information about themselves or their care. Practitioners should therefore discuss with people how they wish information to be shared, and with whom. Wherever possible, this should include what should happen if there is serious concern over suicide risk.*

The consensus statement does not change a practitioner's current legal duties of confidentiality in respect of the people they are caring for, nor does the statement replace the professional guidance available to practitioners. However, the statement is designed to promote greater sharing of information within the context of the relevant law, and to clarify that disclosure is a matter of professional judgement for an individual practitioner.

You question in your report whether a review of the legal duties around patient confidentiality should take place. As you may be aware, in October 2017, the Government announced plans for an independent review of mental health legislation and practice. As a first step towards this, Professor Sir Simon Wessely was asked to chair a full and independent review of the Mental Health Act. '*Modernising the Mental Health Act: Increasing choice, reducing compulsion*'[3], the report of the review, was published in December 2018 and made 154 recommendations.

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[1] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

[3] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

The review did not look at confidentiality and information sharing specifically. However, it did look at the role of families and carers and made a number of recommendations, including moving from the Nearest Relative provision to Nominated Person.

At present, a patient's Nearest Relative has certain powers to protect the rights of the patient, but the patient has no say over who fulfils this role. Allowing the patient to choose their Nominated Person will give people more choice and autonomy about the people involved in their care. The Government has already accepted this recommendation.

In addition, the review recommended that patients should have greater rights to choose to disclose confidential information to additional trusted friends and relatives, including through the Nominated Person nomination process or advance choice documents, and for the Nominated Person to have the right to be consulted on care plans. The review considered that this would ensure more meaningful involvement and also help staff to share information without worrying about potential breaches to patient confidentiality, especially where the patient lacks capacity to make relevant decisions when they are in hospital.

We intend to publish a White Paper by the end of the year, which will set out the Government's response, in full, to the independent review of the Mental Health Act, and pave the way for new legislation to be brought forward when Parliamentary time allows.

As Miss Henry was not detained under the Mental Health Act, the provisions in the Act and the changes we are considering, would not have applied in this case. However, I hope it reassures you that we are taking steps to address some of the concerns which have been highlighted by this case.

Thank you for bringing these concerns to my attention.

NADINE DORRIES