Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

39 Victoria Street
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Mr Graeme Irvine
HM Acting Senior Coroner, East London
Walthamstow Coroner's Court
Queens Road
London E17 8QP

21 July 2021

Dear Mr Irvine,

Thank you for your correspondence of 30 April 2021 to Matt Hancock and the Prevention of Future Deaths report relating to the death of Rohan Dayal Singh. I am replying as Minister with responsibility for mental health services and I am grateful for the additional time in which to do so.

Firstly, I would like to say how sorry I was to learn the circumstances of Mr Singh's death. Whilst I know it may come as little consolation, I nonetheless hope that Mr Singh's family will accept my heartfelt condolences.

I have noted carefully your very serious concerns about the conduct of search, observation and rapid tranquilisation procedures in relation to Mr Singh. It is distressing that the inquest concluded that Mr Singh's death was contributed to by neglect and it is vital that action is taken to ensure such circumstances cannot occur again.

In preparing this response, enquiries have been made with NHS England and NHS Improvement (NHSE & NHSI) and their regional and local partners; and the Care Quality Commission (CQC).

I understand the East London NHS Foundation Trust (ELFT) have provided a detailed response regarding Mr Singh's care, which I will not repeat here. I am reassured by the actions detailed by ELFT, in response to the concerns raised in your report.

NHSE & NHSI have informed the Department that due to the seriousness of the concerns, the Trust took immediate action and discussed these matters with senior leads followed by communication to all nursing staff highlighting expectations in relation to patient searches, observations and rapid tranquilisation monitoring.

The Mental Health Act 1983 Code of Practice[1] provides statutory guidance on how to carry out functions under the Act. It outlines that hospital managers should ensure there is an

[1] *Mental Health Act 1983 (publishing.service.gov.uk)

operational policy for searching patients detained under the Act, their belongings and surroundings and their visitors.

With regards to patient searches, sections 8.37 and 8.38 of The Code state: *A comprehensive record of every search, including the reasons for it and details of any consequent risk assessment, should be made. Staff involved in undertaking searches should receive appropriate instruction and refresher training*.

I have been informed that the Trust has revised its search policy to explicitly include guidance on the handover and review of search information and the disposal or storage of seized items with details of the changes published on the Trust's intranet. Improvements are being made to its electronic medical records system to enable patient searches to be more accurately recorded and monitored and that a new electronic observation recording system is to be introduced.

In addition, actions have been taken around staff training on drug awareness; search and ligature management training; and implementing the search policy, with all staff to receive annual refresher training.

In September 2019 the Trust developed a Joint Protocol with the police regarding the searching of people detained under section 136 of the Mental Health Act 1983.

With regards to the concerns raised about observation of patients, the Trust introduced requirements for all nursing staff to complete the observation policy competency checklist annually and has instituted frequent monitoring and reporting of observation practice.

On enhanced observations, The Code (section 26.34) states *levels of observation and risk should be regularly reviewed, and a record made of decisions agreed in relation to increasing or decreasing the observation*.

I understand the Trust is to provide medical records training which will focus on the legal standard expected for documenting medical practice in relation to observations as set out in The Code.

On the issue of rapid tranquilisation monitoring, section 26.101 of The Code states, *following the administration of rapid tranquillisation, the patient's condition and progress should be closely monitored. Subsequent records should indicate the reason for the use of rapid tranquillisation and provide a full account of both its efficacy and any adverse effects observed or reported by the patient*.

Following the findings of the inquest, the Trust has introduced changes to its rapid tranquilisation policy and procedures to ensure monitoring is only carried out by registered nurses. It has also updated its training programme.

As detailed above, a comprehensive set of actions has been put in place locally to learn from the circumstances of Mr Singh's tragic death and prevent future such deaths.

The Nursing and Midwifery Council (NMC) have informed the Department it will be providing a separate response to you in relation to this case. The NMC code of practice[2] sets out the professional standards that nurses, midwives and nursing associates must uphold in order to be registered to practise in the UK.

[2] nmc-code.pdf

The Code requires all registrants to keep clear and accurate records relevant to their practice and Standard 10.3 states that registrants must not only complete records accurately and without any falsification, but that they have a duty to take immediate and appropriate action if they are aware that someone has not kept to these requirements.

The NMC's authority extends to investigating concerns relating to fraud or dishonest behaviour and to apply sanctions, which include placing restrictions on a registrant's practice or removal from the register so they are no longer able to work in their profession.

DHSC have also liaised with the Care Quality Commission. The CQC has confirmed that the Ivory Ward at the Newham Centre for Mental Health (NCMH) was subject to a remote Mental Health Act review on 23 November 2020, during which feedback for the provider was generally positive and no immediate concerns were identified.

The CQC has informed the Department that ELFT has a history of acting on risks and concerns when identified and received an overall rating of outstanding when inspected in June 2018. The safe and effective domains were rated as good, with caring, responsive and well-led domains rated as outstanding.

In addition, during the spring of 2021 ELFT conducted a full review of patient safety at NCMH. CQC has been closely monitoring progress on this piece of work and is receiving updates on the subsequent actions that have taken place. Information from this review has been added to CQC's monitoring activities with the Trust.

ELFT remains on the CQC's London inspection team risk register and is discussed monthly at the team level and more frequently at the relationship owner and inspection manager level. Further CQC inspections are planned during 2021 and these usually take place unannounced.

The CQC was set up to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and it has a wide range of enforcement powers to use if needed.

You have raised serious concerns. I am reassured that the Trust is taking action, and that the CQC and NMC are aware.

I hope this response is helpful in setting out the actions that have been taken in response to the circumstances leading to Mr Singh's death, and to avoid such occurrences in the future.

Thank you for bringing these concerns to my attention.

NADINE DORRIES