Department of Health & Social Care

[redacted]

From Gillian Keegan MP
Minister of State for Care and Mental Health

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[redacted]

F.A.O Senior Coroner M. E. Voisin
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The Coroner's Court
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Via email **27 October 2021**

Dear Ms Voisin,

Thank you for your letter of 8 July 2021 about the death of Maria Stancliffe-Cook. I am replying as Minister with responsibility for mental health, and I am grateful for the additional time allowed in order for me to do so.

Firstly, I would like to say how saddened I was to read of the circumstances of Ms Stancliffe-Cook's death and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In relation to the matters of concern raised within your report, as you are aware the Avon and Wiltshire Mental Health Partnership NHS Trust commissioned an independent investigation into Ms Stancliffe-Cook's death, the findings of which have been shared with you. I am advised that the Trust has also completed a multi-professional review to consider how staff can continue to work in an autonomous manner whilst maintaining the safe care of patients, and that the Trust has implemented several changes, as a result of these investigatory activities, to improve the understanding and application of risk assessment across the Trust. I am further advised that the Care Quality Commission, the independent regulator for quality, will seek assurance that these actions are undertaken by the Trust. It is of course vital that the Trust takes forward the learnings from Ms Stancliffe-Cook's death.

With regards to the assessment of mental health patients, evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[1], as well as National Institute for Health and Care Excellence guidance[2], suggests that risk assessments must not be seen as a form of risk prediction. It is emphasised that whilst standardised tools may provide the impression of precision, they are poor

[1] https://sites.manchester.ac.uk/ncish/reports/the-assessment-of-clinical-risk-in-mental-health-services/
[2] https://www.nice.org.uk/guidance

in terms of prediction of suicide or a particular behaviour. Instead evidence suggests that assessments should be personalised according to individual circumstances.

At a national level, the Government remains committed to ensuring that fewer people die by suicide each year. Indeed, every suicide is a tragedy that can have a deep impact on families, friends, and communities, and even a single suicide is a suicide too many.

The Department continues to work across Government and with health services and suicide prevention stakeholders, including people with lived experience and those bereaved by suicide, to put in place a scheme of work to prevent future suicides.

In March 2021, the Department published *Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives*[3], which details work across Government and with health service and suicide prevention stakeholders, to reduce suicide rates. It includes action to reduce access to the means to complete suicide. As a result, a process has been established with partners, and across Government, to rapidly signpost emerging methods and take actions through a multi-agency approach. This includes, but is not limited to, limiting access to the method, and reducing or removing material that promotes suicide methods.

Evidence from NCISH has shown that people in contact with mental health services are at highest risk of suicide in the immediate days and months following discharge (200-fold increased risk in the three months post discharge). In view of this, NHS England and NHS Improvement have amended the national post-discharge 7-day follow up standard in the NHS standard contract, to instead require all patients to be followed up within 72 hours following discharge from inpatient mental health care.

Through the NHS Long Term Plan, the Government is investing an additional £57million in suicide prevention by 2023/24. This will see investment in all areas of the country to support local suicide prevention plans and the development of suicide bereavement services.

More broadly, we are increasing investment in mental health services and expanding support for people in crisis. The Government remains committed to the aims of the NHS Long Term Plan to invest at least an additional £2.3billion a year into mental health services by 2023/24. In response to the pandemic, all NHS mental health providers acted quickly to establish 24/7 urgent mental health helplines for people experiencing a mental health crisis. This is an ambition of the NHS Long Term Plan brought forward from 2023/24 to now.

I hope this response is helpful.

GILLIAN KEEGAN

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973935/fifth-suicide-prevention-strategy-progress-report.pdf