Department of Health & Social Care

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

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[redacted]

Nigel Parsley
HM Senior Coroner, Suffolk
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17 December 2021

Dear Mr Parsley,

Thank you for your letter of 9 September 2021 about the death of Joshua Sahota. 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 deeply saddened I was to read of the circumstances of Mr Sahota's death and I offer my sincere condolences to his 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.

Every suicide is a tragedy and learning lessons where things have gone wrong is essential to ensuring that the NHS provides safe, high quality care.

I am advised by the Care Quality Commission (the CQC), the independent regulator for quality in health and social care services, that it has undertaken regulatory activity in relation to Mr Sahota's death, seeking assurance from the Norfolk and Suffolk NHS Foundation Trust of the actions it has taken following Mr Sahota's death, and to address any ongoing risk to patients.

I understand that the Norfolk and Suffolk NHS Foundation Trust has explained in its response to your report that as a result of the internal investigation following from Mr Sahota's death, the Trust has taken a number of actions to reduce the risk of a similar incident occurring. This includes a complete ban on plastic bags on acute mental health wards across the Trust, in addition to a number of improvements, including improved external communications to family and carers, together with a number of safeguards to disrupt the passage of restricted items.

The CQC considers that Mr Sahota's death was an incident of avoidable harm, and, while the CQC has concluded that there are not grounds for a criminal prosecution, the CQC has identified that there was a breach of the regulations (specifically, Regulation 12 – safe care and treatment[1]). Further inspections of the Trust, which remains in special measures, have taken place and I am assured that the CQC will continue to monitor the Trust closely.

[1] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

In relation to restricted or prohibited items on acute mental health wards, you may wish to note that the CQC has published a guide to CQC inspectors[2] on the use of 'blanket restrictions', which lists the items that are likely to be prohibited or restricted on mental health wards, and this includes plastic bags. The guide also describes the principles of risk assessment and personalised care that should be applied to restricted items. Local providers of care should ensure that there is a system in place to ensure that blanket restrictions are reviewed within a regular timeframe, with an overall aim of the reduction of restrictive practices.

On wards where items are restricted or prohibited, there should be auditable standards for how items are identified and what risk assessment is required; how adherence will be monitored and the policy reviewed; and, what information about the restrictions and the reasons for them is provided to patients and visitors.

In relation to plastic bags specifically, a safety alert was published in 2011[3] that highlighted the risks and recommended that providers of services review their policies relating to plastic bags. Mental health services are expected to be aware of the risks and to take the appropriate mitigation.

More generally, I would like to outline the progress we are making in reducing the number of suicides, which, in mental health inpatient settings, have reduced by more than half over the past decade. However, we recognise that the number remains too high. That is why, in 2018, we announced a Zero Suicide ambition, which has led to every mental health trust having a zero suicide policy (or 'suicide safety plan') in place.

This ambition is supported by a dedicated Mental Health Safety Improvement Programme which has a focus on reducing suicide and self-harm in inpatient mental health services, the healthcare workforce and non-mental health acute settings.

Both the Mental Health Safety Improvement Programme and regional suicide prevention leads will share learning on effective approaches to suicide prevention for people in contact with services and support ongoing implementation of the zero suicide plans. In light of the COVID-19 pandemic, NHS England and NHS Improvement will also be supporting mental health trusts to refresh and expand their zero suicide plans to include community settings during 2021 to 2022.

I hope this response is helpful.

GILLIAN KEEGAN

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[2] 20191125_900767_briefguide-blanket_restrictions_mental_health_wards_v3.pdf (cqc.org.uk)

[3] https://webarchive.nationalarchives.gov.uk/ukgwa/20121107183145/http:/www.nrls.npsa.nhs.uk/resources/clinical-specialty/mental-health/?entryid45=130187