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15 February 2022

Dear Mr Allen,

ALEXANDER CHARLES GEORGE TOSTEVIN [redacted] REGULATION 28: REPORT TO PREVENT FUTURE DEATHS DATED 6 DECEMBER 2021

Thank you for your Regulation 28: Report to Prevent Future Deaths dated 6 December 2021 following the Inquest into the tragic death of Cpl Tostevin on 18 March 2018. You concluded his death was as the result of suicide and have raised concerns regarding the provision of support to Service Personnel facing mental health challenges. I take the health and wellbeing of members of the Armed Forces extremely seriously and very much share your desire to mitigate the risks of future such tragedies.

In considering my reply, I have taken advice from the Commander Defence Primary Healthcare and the Defence Consultant Advisor for Psychiatry and received information from Cpl Tostevin's Unit on how the handling of issues around mental health and wellbeing have evolved since 2018. I also draw on some wider context from the Armed Forces People Team.

I would observe that Defence has been working hard to remove the stigma around, and provide effective support for, mental health issues amongst our Service population. Sadly, as with wider society, we cannot completely eradicate the risk of suicide. However, the *Defence People Mental Health and Wellbeing Strategy*[1] sets out our commitment for: *"All Defence People to enjoy a state of positive physical and mental health and wellbeing, feeling connected with and*

[1] Defence people mental health and wellbeing strategy - GOV.UK (www.gov.uk)

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Enclosures: 2021DCMHSOP-03-03-18 Confidentiality Guidelines for DCMHs and MHTs
DCMH and RNFPS Joint Working Protocol – dated Mar 2

supported by the military and wider community. The risk of suicide can be mitigated through the application of robust, pragmatic policies based on detection, early intervention and prevention by tackling stigma, education and enabling access to mental health support and healthcare services.

I am confident that we are making progress in supporting the mental health of our Armed Forces. This is an ongoing journey, which is supported and driven by the MOD-wide Service Personnel Suicide Prevention Working Group (SPWG) - established in November 2018- which coordinates suicide prevention policies across Defence and identifies and shares best practice. On 2 December 2021, the group agreed to develop a Defence Suicide Prevention Plan. The SPWG also recommended the creation of a Defence Suicide Register (DSR), which is currently being developed, to provide the evidence base to inform the MOD suicide prevention strategy.

Your Regulation 28 Report relating to the death of Cpl Tostevin in March 2018 raises a number of important matters. I have addressed each issue below.

Dorset Coroner's Matters of Concern Paragraph 2.i. reads as follows: *"The lack of independence of DCMH services risks service users minimising and/or under reporting the risks they may pose to themselves for fear that information may be disclosed to the Chain of Command. If the true extent of the risk of suicide is not known by DCMH, an effective risk management plan to mitigate the risk of suicide cannot be formulated".*

Situations where service personnel mask their own concerns or provide different information to different mental health and support services, invariably produce very challenging circumstances for those seeking to provide support. Defence's approach to disclosing information and encouraging people to seek mental health support aims to ensure Department of Community Mental Health (DCMH) is provided with the information it needs to formulate effective risk management plans in each case. I will address each area in turn.

Disclosure of information between DCMH and the Chain of Command.

DCMH operates as an independent organisation, which sits within Defence Primary Healthcare (DPHC), a Tri-Service organisation in UK Strategic Command. Although military DCMH staff[2] are drawn from the medical services of the Royal Navy (RN), Army and Royal Air Force (RAF), DCMH is independent of all three Service chains of command. Mental health services play a vital Occupational Health role in supporting the Unit and the holistic care of Service personnel. Therefore, a close relationship with an individual's Chain of Command and DPHC is often a key to ensure the best possible outcome for personnel experiencing mental health issues.

[2] DCMH staff can be both civilian and military.

Service personnel are entitled to a confidential medical service, which mirrors medical confidentiality applied in the civilian population. As Registered Healthcare Practitioners, DCMH clinical staff comply with the framework of the Caldicott Principles[3] and the extensive guidance provided by the General Medical Council regarding confidentiality[4].

DCMH best practice is for confidential patient information to be shared only with the patient's consent. However, disclosure of confidential patient information without consent may be justified in *exceptional* circumstances to protect the individual or someone else from possible harm or where it is in the public interest to do so. Holistic care does become more challenging when consent is not given and the threshold for sharing without consent is not reached. DCMH staff will provide guidance on how the affected personnel should be employed and managed while receiving care. Examples of information which can normally be shared without consent are laid out in DPHC Standard Operating Procedure (DCMHSOP) 03-03-018 (Enclosure 1) which reads:

> *The following information can normally be disclosed to an appropriate member of Command without patient consent:*
>
> *a. The occupational limitations that apply to the patient (iaw what they can and cannot do), but **not why** the limitations are recommended.*
>
> *b. The patient's schedule of appointments.*
>
> *c. The anticipated duration of any restrictions.*
>
> *d. Any risk information Command must know, as actions are required from them to manage it or monitor it…If in doubt that the threshold for disclosure has been reached, consult senior colleagues in your DCMH in the first instance, or alternatively contact one of the DCAs [Defence Consultant Advisors].*

Such guidance may include an individual being precluded from driving military vehicles, being placed on guard, or having access to weapons or ammunition restricted or denied. This allows for appropriate measures to be taken to ensure the safety of the individual and others without the need for sharing of confidential patient information.

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[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942217/Eight_Caldicott_Principles_08.12.20.pdf

[4] Staff must also comply with all other relevant data protection legislation when sharing information.

Any independent provider of mental health services to Service personnel (i.e. one which sits outside of Defence) holds the same duty of confidentiality and would operate within an identical legislative and regulatory framework. However, informed advice from military clinical staff, helps ensure that serving personnel can be employed productively and safely, while managing their mental health issues.

Managing SPs Underreporting Symptoms.

Without consistency and openness, making an accurate assessment of a person's mental health can be extremely difficult. I have provided more detail below regarding how Defence, including Cpl Tostevin's Unit, approaches such matters.

Societal stigma regarding mental health issues has reduced in recent years but does endure. This is a recognised risk within service communities with regards to the management of vulnerability. Cpl Tostevin's Unit has now adopted the Army General Administrative Instruction (AGAI) 110 – *Vulnerability Risk Management (VRM)*[5], which acknowledges the ongoing challenges, stating:

> ***"****Stigma is a cultural issue and it is the responsibility of every commander and individual to address it. Men in general, and male Army personnel in particular, have been shown to delay seeking help due to lack of insight, stigma and fear that disclosure of their personal circumstances will be seen as a sign of weakness and/or have an adverse effect on their military career".*

To support commanders with addressing stigma, programmes across each of the Services have been developed to help improve mental fitness and resilience, and help-seeking behaviours within the Service population (see Annex A for further information).

Since 2018 Cpl Tostevin's Unit has established further measures to improve both mental health resilience and management. The Wounded in Service Warrant Officer (WISWO) position, a key post within the Unit dedicated to managing injured personnel, has received significant investment in the past three years, with increased continuity of the individual in post, and additional workforce capacity to assist in the management of down-graded personnel. This has better supported stable and trusted relationships between the WISWO, the wider team and the individual under their immediate care. Infrastructure to house and

[5] Information regarding AGAI vol 3, chapter 110 Army suicide vulnerability risk management (SVRM) policy (publishing.service.gov.uk)

administer personnel in recovery has also developed significantly, providing spaces for recovering personnel to discuss issues in a safe and supportive environment.

In addition, an in-unit support team delivers briefs (including mental health, sleep, hygiene, and coping strategies), which complements the work of the Royal Navy Family Personnel Services (RNFPS) (Welfare) team, WISWO and clinicians. These briefs are delivered to new joiners and existing personnel. The collective aim is to raise awareness of what personnel should look for in their colleagues and in themselves to identify mental health concerns. Wellbeing initiatives have also progressed, including a poster campaign which uses anonymised QR-coded signposting to increase access to physical/mental health support and material.

The Unit also receives enhanced support from an embedded, independent, psychiatric nurse- a key asset in promoting mental health and wellbeing. The Unit is also exploring options to increase DCMH endorsed clinical mental health support and dedicated psychologist support. Each squadron has its own General Practitioner supported by a full-time medic. The close relationship between the Chain of Command and medical/welfare practitioners continues to enable any stigma associated with mental health issues to be combated, while also ensuring mental health First Aid measures can be implemented early and referrals made in a timely manner to ensure our SP are effectively supported.

Dorset Coroner's Matters of Concern Paragraph 2.ii. Paragraph 2.ii. of Reference A reads as follows: *"The primacy of the view of DCMH when considering the risk of suicide in MDT/Case Conferences again means that the true risk of suicide may not be accounted for, particularly where a service user is providing different information to DCMH and Welfare and/or where there is disagreement between DCMH and Welfare as to the presenting level of risk. Adapting a process similar to a Multi-Agency Risk Management Meeting (MARM) or Multi-Agency Risk Assessment Conference (MARAC) in a civilian context may assist: in a MARM or MARAC, the level of risk adopted is the highest level raised in the meeting / conference, without any agency having primacy. Therefore, the risk management plan subsequently formulated addresses the highest level of risk bought to the meeting."*

While each Service has its own policies and frameworks to manage its vulnerable personnel, every case across Defence is Chain of Command led and supported, as appropriate, by welfare agencies, pastoral support and healthcare professionals (including DCMH). Cpl Tostevin's Unit applies the Army's Vulnerability Risk Management (VRM) Framework, which states:

> *"The CO is responsible for deciding whether an individual should be considered at risk of suicide or self-harm behaviours, formulating the management response and selecting the appropriate measures to reduce risk. They must ensure close collaboration with the immediate Chain of*

Command, welfare, pastoral and medical personnel and, most importantly, the individual at risk."

It also states: *"COs are advised to err on the side of caution and place individuals on the VRM register[6] in circumstances where there is any doubt".*

For personnel on the VRM, Command-led multidisciplinary meetings are held to produce and maintain a management strategy that incorporates pastoral, medical and welfare input, as well as the views of the affected individual. Cpl Tostevin's Unit uses the Army framework for such case conferences, which results in the production of a Care Assessment Plan (CAP) ~~(see below for more detail).~~ The policy makes clear that a conference must take place and directs who should be present to allow the CO to make an informed decision from all around the table (CoC, Welfare, Medical, Pastoral etc). The overt aim therefore is to secure a holistic representation of views across the agencies involved, from which a balanced, considered view of risk can be reached. The opinion of DCMH carries due weight, while also being balanced against opinions provided by the welfare agencies or the individual's own immediate Chain of Command. In cases where the individual is under the care of the DCMH, this construct complements the professional medical care provided by the Defence Medical Services, as appropriate clinical care will already be in place.

Since the tragic passing of Cpl Tostevin, to ensure this process runs effectively in the Unit, a joint working protocol between DCMH and the Royal Navy Families and People Support (RNFPS) team was agreed and signed in March 2020. A copy of this protocol is provided at Enclosure 2. This outlines the actions to be taken in cases where disagreements occur between the two organisations, which promotes improved lines of communication accounts for all views to ensure the wellbeing of the individual is protected.

Dorset Coroners Matters of Concern Paragraph 2.iii. Paragraph 2.iii. of Reference A reads as follows: *"Where there is no composite risk assessment and care plan document that draws together all the relevant information for a patient and identifies the plan in place at any given time, there is a risk that key information and risk factors are missed".*

In line with AGAI 110, composite CAP documents based on a holistic assessment of risk are now in place within Cpl Tostevin's Unit. The Case Conferences continue to employ a multi-disciplinary approach to managing personnel deemed to be at risk, with carers' meetings being conducted fortnightly. Meeting attendees now feed into a collaborative tool to manage vulnerable personnel, which is hosted on the Vulnerability Risk Management Information System (VRMIS).

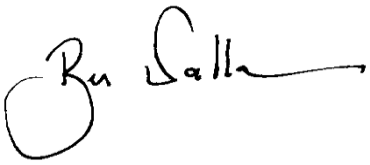
[6] Please see AGAI 110 publication for more information on the VRM register.

The use of VRMIS enables a single CAP to be produced, collating the advice and opinions of all those responsible for an individual's care. Once the initial CAP is completed on VRMIS, carers then feed their relevant amendments as required via the nominated CAP lead (usually a specified individual within the Chain of Command). When the CAP is updated with information from any of the carers, an instant electronic notification of the changes is sent to all members of that specific carers group, informing them of the change. These measures together are designed to ensure that a single holistic care plan is contributed to by all interested parties and that real time information is passed to carers should the information on the CAP change.

Thank you for raising your concerns with me. I hope you will appreciate from my response that lessons have been learned. With the adoption of AGAI 110 in Cpl Tostevin's former Unit, the investment in the WISWO team, welfare infrastructure and the disagreement resolution agreement between welfare agencies and DCMH, which collectively contributes to an improved, more streamlined management process for those at risk of self-harm or suicide. I recognise there is more work to be done within the Unit and across the organisation. Defence remains committed to further improving the care of those with mental health challenges and, driven by the SPWG, work will continue to further reduce the risk of suicide across all of our Armed Forces to as low as possible.

My thoughts remain with Cpl Tostevin's family and I hope this will provide some element of solace to them following their tragic loss.

Yours sincerely,



THE RT HON BEN WALLACE MP

Annex A: Further Information on Single Service Mental Health Initiatives

a. **Royal Navy**. The RN utilises a mixture of the Army Mental Fitness Training programme and the Royal Marine initiative Project REGAIN- designed to encourage all ranks to seek help if they have concerns about their mental health. RN Human Performance team are also identifying how to improve mental health learning, leadership the culture of reporting concerns in self and others. Mandatory mental health briefs from designated nurses, online tools and wellbeing apps have also been utilised.

b. **Army Mental Fitness and Resilience Training**. As part of Op SMART, a comprehensive Army framework was created to improve mental health literacy, reducing stigma associated with mental health short term performance and long-term mental health outcomes. This was achieved by the creation of a mental resilience and mental fitness training and education program that delivered personal, psychological and social skills that was embedded throughout the career pathway.

c. **RAF Thriving at Work**. The RAF have invested in research and developed a comprehensive Whole Force specialist mental health and wellbeing programme called Thriving at Work (T@W). T@W is about Leadership, support, communications, and treatment. It makes best use of existing resources, tools and agencies and is inclusive of civil servants.