



Department
of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

POC1_817376

Mr A Walker
Senior Coroner
North London Coroner's Court
29 Wood Street
Barnet
London
EN5 4BE



Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

20 DEC 2013

Dr A. Walker,

Thank you for your letter following the inquest into the death of Daniel Maurice McMahon. In your report you state that Mr McMahon died from head injuries after being struck by a train leaving Willesden Junction Underground Station. At the time of his death, Mr McMahon had been on leave from Park Royal Hospital while undergoing treatment under the Mental Health Act.

I understand the London Ambulance Service will reply to you directly on your concern about their crew's use of a decompression needle without a valve.

In your list of concerns you ask that the Department of Health considers:

- using a feedback form, where a patient is on leave under S17 of the Mental Health Act, to be completed by those caring for the patient in the community and the professional staff at the hospital to ensure that any difficulties the patient has whilst on leave are picked up.

In relation to the care of mental health patients, we would advise that everyone referred to secondary mental health services should receive an assessment of their mental health needs. If it is agreed that the person's needs are best met by a secondary mental health service, a care plan should be devised. Services should aim to develop one assessment and care plan that will follow the service user through a variety of care settings to ensure that correct and necessary information goes with them.

In reviewing a care plan as part of discharge planning from hospital or other residential settings, appropriate liaison with mental health services in the community is essential. The period around discharge is a time of elevated risk, and particularly of self-harm. This underlines the need for thorough review and assessment prior to discharge and effective follow-up and support after discharge.

Mental health trusts should ensure that individuals with higher support needs are identified and appropriately supported. All care plans must include explicit crisis and contingency plans. This includes arrangements so that the service user or their carer can contact the right person if they need to at any time with clear details of who is responsible for addressing elements of care and support.

We are currently reviewing the advice in the "Code of Practice Mental Health Act 1983". This includes reviewing the chapter on leave of absence under section 17 of the Mental Health Act 1983 and the references to care planning. The experience of this case will be used to assist that review.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Mr McMahon's death to my attention.

Yours sincerely
Jeremy

JEREMY HUNT