Department of Health

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

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POC1_821412

Your Ref: 2012-891/DP

Mr I Smith
Senior Coroner
Central Police Station
Market Street
Barrow-in-Furness
Cumbria
LA14 2LE

10 DEC 2013

Dear Mr Smith,

Thank you for your letter following the inquest into the death of Kathleen Rosemary Dixon. She had been in the care of Cumbria Partnership NHS Foundation Trust (the FT) and drowned herself in the local river on 19 December 2012.

You found that she had a history of mental health problems, had been in the care of the FT and was assessed and released into the community. She committed suicide shortly afterwards.

You raised your concerns that:

i) this case mirrored the circumstances of a number of other cases, within the same FT, where the mental health of either an in-patient or a community patient has been wrongly assessed and within a very short time of being released into the community the person committed suicide;

ii) these deaths have occurred sufficiently frequently to cause you to question whether this is a symptom of a deep rooted problem within the FT.

You have also written to the Care Quality Commission (CQC) about this matter. My officials have discussed this case with CQC and have confirmed that the CQC is aware that there are problems of the nature you describe at the FT.

In October 2013 the CQC issued two warning notices to the FT in relation to the care and welfare of people who use services and staffing and has told the FT that it must make improvements to comply with national standards of quality and safety.

On 28 November 2013 the CQC published an inspection report following the inspection of the FT's Ramsey Unit, an adult mental health facility at Furness General Hospital, Barrow, which identified shortfalls against three of the national standards reviewed.

The FT has agreed to fully address all areas of concern and CQC, working closely with NHS England, Monitor and commissioners, will monitor the position to ensure that the required improvements are implemented.

This Government is committed to ensuring that the health and care system prevents problems, detects problems quickly and takes action promptly where they occur. Since the publication of the Mid Staffordshire NHS Foundation Trust Inquiry, the Government has instigated a number of changes which will improve inspection, increase transparency, put a clear emphasis on compassion, standards and safety, increase accountability for failure, and build capability. "Hard Truths", the government's response to the Mid Staffordshire NHS Foundation Trust, set out additional actions to improve patient safety.

In relation to the care of mental health patients generally, 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.

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

Yours sincerely

Jeremy Hunt

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