From Rt Hon Norman Lamb MP
Minister of State for Care and Support

Department of Health

Department of Health
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Ms R Cobb
Senior Coroner
Coroner's Office, Kent County Council
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21 OCT 2014

Dear Ms Cobb,

Thank you for your letter following the inquest into the death of Joshua Brown. In your report you state that Mr Brown took his own life while suffering from depression, the clinical cause of death being from multiple injuries sustained after falling from the top of a cliff.

Mr Brown had a history of self-harm and suicidal thoughts and in 2011 had verbally indicated his intention to take his own life. He had been diagnosed with moderate depression and maladaptive personality traits and was in the care of the Community Health Team (CHT).

I was sorry to read of Mr Brown's death and wish to extend my sincere sympathies to his family.

Your main concerns appear to arise from the fact that Mr Brown did not wish his personal information to be shared with his family. In particular, you raise the following points:

- Mr Brown lived at home with his parents and although they were his primary support they were not his carers. Mr Brown did not wish information about himself to be shared and so the CHT were not able to involve his parents formally. His parents therefore did not receive information that might have alerted them to when Mr Brown was particularly vulnerable, and equally information which might have been of assistance to the CHT caring for him was not passed on.

- It was not the practice of the CHT to confirm the accuracy of notes they had made with family members with the consequence that inaccuracies or misunderstanding may have arisen in some of the notes. There was therefore no provision for these notes to be signed as accurate by the relevant family members.
- Family members were not made aware of how to obtain information through the Kent and Medway NHS Trust about ways they could best support Mr Brown and themselves.
- There were limitations for engagement by the CHT with family members, particularly because Mr Brown did not wish his information to be shared – this worked to his disadvantage.

Current legislation provides that, where a clinician believes that a patient is at risk of suicide, and that patient refuses to provide consent for information to be shared with family members or any other third party, and, in the judgement of the clinician, the patient has full mental capacity to understand the risks, then disclosure of that patient's confidential information is not warranted.

In such circumstances the clinician needs to consider the risks to his or her own relationship with the patient – the patient may withdraw from treatment if he or she does not believe the clinician will respect confidentiality. Breaking patient confidentiality could also create a risk that future patients will fail to seek treatment because they do not trust the NHS to provide a confidential service.

The Department has received feedback from a number of families bereaved by suicide about their experiences with services. Issues of confidentiality have been a recurring theme. The public has repeatedly raised concerns that practitioners can seem reluctant to use information from families and friends or provide families with information about a person's suicide risk. Several Prevention of Future Deaths reports from Coroners have also drawn attention to this situation.

The Department has therefore facilitated a consensus statement on confidentiality, *Information sharing and suicide prevention: consensus statement,* which was published in January 2014 alongside the first annual report on the suicide prevention strategy.

Both of these documents are published on the Government website:

https://www.gov.uk/government/publications/suicide-prevention-report

The consensus statement says:

"We strongly support working closely with families. Obtaining information from and listening to the concerns of families are key factors in determining risk. We recognise however that some people do not wish to share information about themselves or

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their care. Practitioners should therefore discuss with people how they wish information to be shared, and with whom. Wherever possible, this should include what should happen if there is serious concern over suicide risk."

To expand on this, the consensus statement advises that there are times in dealing with a patient at risk of suicide when practitioners will need to consider informing the family and friends about aspects of risk and may need to create a channel of communication for both giving and receiving information that will help keep the person safe.

The statement recommends that practitioners routinely discuss and confirm with patients whether they wish their family and friends to be involved in their care generally, and whether they wish for information about themselves to be shared. The patient's view on who should be involved (and potentially, who should not be involved), should there be serious concern over suicide risk, needs to be discussed, considered and recorded.

In cases where these discussions have not happened in advance, a practitioner may need to assess whether the patient, at least at that time, lacks the capacity to consent to information about a suicide risk being shared. The Mental Capacity Act makes it clear that persons must be assumed to have capacity unless it is established that they lack capacity, and that people are not to be treated as unable to make a decision merely because they make unwise decisions. However, if a person is at imminent risk of suicide there may well be sufficient doubts about mental capacity at that time.

In these circumstances, a professional judgement will need to be made, based on an understanding of the patient and what would be in the patient's best interest. This should take into account the patient's previously expressed wishes and views in relation to sharing information with family, and, where practical, include consultation with colleagues. The judgement may be that it is right to share critical information. If the purpose of the disclosure is to protect a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information, where it is considered to be in the person's best interest to do so.

This work was supported by our National Suicide Prevention Strategy Advisory Group. The consensus statement will be discussed again at the next meeting of this group in November 2014.

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

Yours sincerely,

[redacted]

NORMAN LAMB