Department of Health

POC5 913654

From Dr Dan Poulter MP
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Mr A Walker
Senior Coroner
H.M. Coroner's Court
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Dear Mr Walker,

Thank you for your letter following the inquest into the death of Dale Proverbs.

I was very sorry to hear of Mr Proverbs' death and wish to extend my sincere condolences to his family.

Mr Proverbs had been detained under the Mental Health Act 1983 and placed in seclusion at a north London clinic, run by Partnerships in Care (PIC). While at the clinic, Mr Proverbs was intended to be under continuous observation, as stipulated in PIC policy.

A nurse was assigned to observe Mr Proverbs. However when Mr Proverbs collapsed in his room it was not noticed until 15 – 20 minutes after the nurse's last direct observation and communication. An ambulance was called, but Mr Proverbs suffered a ventricular fibrillation which led to his death.

You state that the use of Clopixol is the most likely of a number of possible causes of the ventricular fibrillation that led to Mr Proverbs' death. You also say that neglect shown in the lack of implementation of PIC policy on continuous observation of a patient in seclusion contributed to Mr Proverbs' death.

I understand that in response to the issues raised at the inquest, PIC redrafted their policies to conform exactly to the 2008 Mental Health Act 1983 Code of Practice. I appreciate that you consider that the PIC policies in place at the time of the death demanded a higher standard of observation for secluded patients than is detailed in the Code of Practice. However, the Code of Practice reflects the government's commitment to improving mental health services, and to protecting the most vulnerable in society and has recently been revised to reflect substantial changes and updates in legislation, policy, case law, and professional practice.

Staff failure in this case to adhere to the standards of observation set out either in PIC's own policy or in the Code of Practice are matters for PIC management. I note that you have sent a copy of your Regulation 28 letter to PIC and I would expect them to address any such outstanding issues.

Your main concern is however that the levels of observation recommended in the MHA Code of Practice for patients in seclusion are not sufficient enough to prevent a death from occurring in similar circumstances.

The Mental Health Act 1983 Code of Practice states that *"a suitably skilled professional should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion."*

The Department of Health has recently completed a thorough review of the Mental Health Act 1983 Code of Practice which, subject to parliamentary approval, will come into effect on 1st April 2015. As part of this procedure the requirements for reviewing seclusion have been strengthened with changes to the timing and frequency of formal reviews of the ongoing need for seclusion.

The draft being considered by parliament requires that seclusion should be *'applied flexibly and in the least restrictive manner possible, considering the patient's circumstances'*. The overall requirement for observation quoted above has not been changed. However, for patients who have received sedation there is a requirement that a skilled professional is outside the door at all times.

The Code goes on to explain that *'the aim of the observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end'*. This acknowledges the importance of proper observation but also takes account that constant observation is not always appropriate and could in some circumstances be more restrictive than is necessary.

The National Institute for Health and Care Excellence (NICE) is currently developing guidelines for the management of violence and aggression. Their consultation draft takes a similar approach to the Code, with a higher level of observation required where patients have been sedated.

In addition, the National Confidential Inquiry into Suicide and Homicide (NCISH) is currently undertaking a review of constant and intermittent observation on mental health units entitled, *"In-patient suicide under non-routine observation"* and will publish results in March 2015. Following this, NHS England is planning work with other organisations to ensure that findings of the NCISH report, including those which relate to improving the reliable delivery of effective observation, are considered and implemented.

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

Best wishes,

DR DAN POULTER