Department of Health

From Jackie Doyle-Price MP
Parliamentary Under Secretary of State for Mental Health and Inequalities

Department of Health and Social Care
39 Victoria Street
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Our reference: PFD 1120331

Ms Sonia Hayes
HM Assistant Coroner South London
Coroner's Service
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08 MAY 2018

Dear Ms Hayes,

Thank you for your letter of 14 February to the Secretary of State about the death of Ms Julia Jane MacPherson. I am responding as Minister with responsibility for Mental Health and I am grateful for the extra time in which to do so.

Your report raises several areas of concern, most of which are operational matters for the Oxleas NHS Foundation Trust.

I wish to provide comment in relation to the area of concern that there is no statutory process for recording consent to medication for voluntary (or informal) patients receiving mental health treatment, as there is for patients who are detained under the Mental Health Act.

As you will be aware, voluntary patients should have the capacity to understand and provide consent to their treatment. Voluntary patients should be given sufficient information by their responsible clinician about proposed treatment to make an informed choice. The capacity of voluntary patients to give consent to treatment should be regularly assessed and considered by the multidisciplinary team supporting the patient. Where there are concerns about the patient's capacity, the patient's voluntary status should be reviewed and detention sought where clinically appropriate. Chapter 14 of the Mental Health's Act's Code of Practice[1] discusses how this should take place.

[1] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

It is sadly regrettable that on this occasion a medication review and a review of Ms MacPherson's capacity to consent to treatment did not take place.

Learning lessons where things have gone wrong is essential to ensuring the NHS provides safe, high quality care. I am aware that the Trust has responded to you on these matters separately advising the steps it is taking to address the areas of concern highlighted. This includes additional safeguards for patient's prescribed off licence medication whereby the ward pharmacist will review the medications and ensure that all processes, including capacity assessments and efficacy of treatment, are being checked and documented, bringing any concerns to the attention of the responsible clinician and clinical director.

I understand that the Care Quality Commission (CQC) has responded to you to advise that its comprehensive inspection of the Trust conducted in 2016 did not highlight any significant issues around the areas of concern highlighted through the Inquest into the death of Ms MacPherson. CQC will be returning to the Trust later this year and will ensure the Trust has made the necessary improvements. I hope this provides further assurance.

Thank you for bringing the circumstances of Ms MacPherson's death to our attention.

JACKIE DOYLE-PRICE