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16 February 2021

Dear Ms Hayes,

Thank you for your letter of 19 November 2020 in which you enclosed a copy of your Regulation 28 Report following the Inquest into the very sad death of Sgt Paul Hills. Suicide is a tragedy, not only for the individual and their family, but for us as an institution; we owe a unique debt of gratitude towards those who serve. I very much share your desire to prevent any recurrence of such tragic events and I am grateful to you for bringing your findings to my attention.

I set out below the steps that have already been taken on the issues you have raised, and the further action planned.

The challenge of improving the mental health and wellbeing of our Armed Forces personnel is an important one. In July 2017, the Defence People Mental Health and Wellbeing Strategy was launched, emphasising the continued need for a coordinated approach to prevent, detect, and treat mental health and wellbeing issues, as well as introduce measures to promote the importance of mental health. The Ministry of Defence (MOD) provides a 24-hour mental health helpline for Armed Forces personnel and their families allowing them to access support for mental health problems and a new online platform, HeadFIT, was launched in 2020 with tools and techniques to support to the Armed Forces community manage good mental fitness and resilience. From April 2021, mandatory, annual, military mental health and wellbeing training will be introduced as part of a redesign of mental health provision in the Armed Forces.

Matters of Concern 1 – *"No risk assessment was completed on the issue of moving mental health appointments to virtual during the COVID-19 pandemic and how patients could be kept safe in the event of deterioration in his mental health. There was no plan in place for patients that required urgent assessment/review due to deterioration in their mental health."*

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We recognise the importance of face to face appointments for urgent clinical assessments, particularly with respect to mental health matters. Throughout the COVID-19 pandemic in-person consultations have been offered to patients who are assessed as being at high risk. However, the pandemic has meant that in-person attendance is not always possible, or indeed preferred, by some individuals. In making available remote video consultation during the pandemic, the MOD prioritised mental health services in recognition of the particular needs of such cases. The "Attend Anywhere" platform is now available for appointments to be conducted remotely. The use of video allows our clinicians to identify additional diagnostic clues and facilitates a therapeutic presence, despite not being able to meet a patient in person. Telephone consultations, as used in the early stages of the first COVID-19 lockdown, remains as an alternative option where face-to-face meetings or remote video consultation cannot be conducted.

The provision of mental healthcare follows a stepped approach, following the introduction of the Defence Mental Health Unified Care Pathway in March 2018. Care starts with an individual's General Practitioner in Primary Care and may be stepped up to our bespoke military mental health service if required: this may be because treatment in the Primary Care setting has proved to be ineffective, or that specialist mental assessment and intervention is necessitated from the outset. The Defence Mental Health Service is based on the provision of community mental health services through a series of regional centres (Departments of Community Mental Health and associated mental health teams). Inpatient mental healthcare services are provided under contract by Midlands Partnership NHS Trust that leads a consortium of eight NHS providers throughout the UK.

Sgt Hills' risk was assessed by treating clinicians in Department of Community Mental Health, London, and as a result he was offered a face-to-face appointment. Following discussion with Sgt Hills, who was concerned about attendance in person, a telephone appointment was agreed as an alternative. We agree that the factors his clinicians considered in proceeding with telephone consultations should have been documented more clearly. Steps have now been taken to ensure better record keeping. This is covered in more detail below, in the response to your matters of concern 2 and 4.

As outlined above, there is a stepped approach to the provision of mental healthcare. The assessing clinician will consider the severity of a patient's condition. This is largely a decision based on clinical assessment and observation. In a case where a patient is significantly deteriorating, MOD has processes in place to arrange, at any time, emergency admittance to an inpatient mental health unit. Service personnel are assessed, stabilised and treated in hospitals as close to their home or parent Unit as possible.

In Sgt Hills' case, he was not offered hospital admission. This was based on a clinical assessment of his mental state, together with consideration of protective factors such as the support from his family, friends and employer.

Matters of Concern 2 – "*The Care plan had not been updated since October 2019 and his risk assessment remained the same even when the scores changed and there was evidence of escalating risk behavior*"

Matters of Concern 4 – *"His risk assessment was not up-to-date and his disclosures during April were not documented."*

In your matters of concern 2 and 4 you raised the lack of detailed record keeping and risk assessments. You rightly highlight the importance of clear and accurate recording of all aspects of patient care to ensure a coherent history. Record keeping is an essential tool for communication between clinicians and for effective care planning. There is clear guidance set out in Defence Primary Healthcare standard operating procedures on the standards required, and all patient medical and clinical documentation should be recorded electronically on the MOD case management system. The guidance is clear that all routine clinical notes should be entered directly on to the patient's electronic file, and any handwritten notes shredded after that happens.

Sgt Hills' care plan was updated on a number of occasions and his risk levels were being reviewed. However, the records of this case were not to the standard expected. Sgt Hills' initial care plan, dated October 2019, formed the basis for treatment. Within a Department of Community Mental Health, subsequent updating of the care plan is part of the overall treatment record, which clinicians document on a review/assessment template. On this template, there is a section for recording any updates to the care plan, or to confirm the extant care plan, as well as assessment of risks, clinical reasonings and any prescribed medication.

During the inquest, printouts of the review/assessment template were provided: however, the purpose was not clearly explained and in Sgt Hills' case the review/assessment template had not been completed with the level of detail and clarity expected. As a result, it was not clear that from the printout provided in evidence at the Inquest, that Sgt Hills' care plan had been updated on five occasions after October 2019, (23/12/19, 10/02/20, 28/02/20,19/03/20 and 02/04/20). I regret that this was not clearly explained at the Inquest.

You will wish to be aware that the treating clinician involved is receiving monthly caseload supervision from a Senior clinician (normally this form of supervision is carried out every six to eight weeks). This will ensure that the individual's casework management, including the completion of the review/assessment record, is to the detail required and contains sufficient clinical rationale to demonstrate a coherent picture of care. This monthly supervision will continue for the rest of this year. If the treating clinician's performance has improved, his caseload supervision will return to the normal six to eight-week cycle. The treating clinician has also undergone further training in risk assessment management.

More broadly, steps have been taken to ensure that Senior clinicians focus on the quality of record keeping and, should the performance of any treating clinician fall below the expected standard, that person's performance will be reviewed regularly until the required quality is achieved. To support this, Defence Primary Healthcare is currently updating its guidance on the delivery of mental healthcare to ensure clinicians, Departments of Community Mental Health and Regions have the support they require and can be held to account for their adherence to clinical policy.

Matters of Concern 3 – *"Risk issues were not shared with the family even though Sgt Hills was in lockdown with them and there were no discussions regarding sharing of information. He disclosed his dry runs of self-strangulation on 28th February and 16th April and his withdrawal/isolation from his family who had been very supportive of him. On 22nd April he disclosed he was looking for a rafter to harm himself from and there was an overreliance on his family as a protective factor in the absence of this knowledge being shared with them."*

On the issue of risk management, Defence Primary Healthcare is introducing enhanced risk management training for all Department of Community Mental Health clinical staff. This will be delivered by a recognised national provider and will be completed for all mental health clinicians by the end of March 2021. The training will provide best-practice tools to recognise, assess and manage risks for mental health and related matters.

You have raised important points about communication with families around issues of risk, and we recognise the invaluable support provided by loved ones in often distressing circumstances. As you will appreciate, if a patient is receiving mental health support, there is no routine engagement with families as some patients might not want their family to know that they are receiving treatment. If the patient refuses permission for his or her clinician to contact their family, this will be considered as part of the risk management procedures, and in accordance with guidelines on the disclosure of patient information. I understand Sgt Hills' consultant was in contact with his family, however, I do appreciate your concern, and this will be addressed further in the risk management training.

Matters of Concern 5 – *"Sgt Hills was advised not to drive with his wife and children in the car when he disclosed strong thoughts to drive head long into oncoming traffic. This advice would not have protected Sgt Hills or other road users."*

You have raised a specific concern about individuals who are a risk to themselves and others when driving. For patients with mental health issues, it is especially important to carry out and record an appropriate risk assessment: this should include the risk of driving and form a standard part of all consultations even if the assessment of risk is considered low. I understand that Sgt Hills was advised not to drive and to inform the Driving and Vehicle Licensing Agency (DVLA) of his medical condition, in accordance with DVLA guidance, to mitigate risk to himself and others. I also understand that Sgt Hills advised his clinicians that he did not intend to drive and had arranged that his wife would drive him to his appointments. A staff vehicle and driver were also made available to transport him to his medical appointments.

However, I recognise the significance of this concern and about the way this issue may have been approached - this would not have protected Sgt Hills or other road users. In future, Clinicians will be required to provide evidence where an individual has been instructed not to drive and to advise the DVLA, to ensure that this can be monitored throughout care.

Matters of Concern 6 – *"Evidence was heard during the inquest that RAF Manston was being decommissioned and this impacted on the treatment available locally for Sgt Hills and impacted on communications with the DCMH and the sharing of relevant information."*

I note your concern, but I hope I can rectify any misunderstanding created at the Inquest about the planned closure of RAF Manston. Department of Community Mental Health clinicians were aware that the Defence Fire Training Development Centre Manston[1] was being decommissioned. Some confusion may have arisen about the gap between the MOD-wide announcement of the planned closure of the site and the planned decommissioning date itself. The decommissioning of the Centre did not begin until November 2020. Before and during April 2020 the Centre was still carrying out its assigned training tasks and all key staff remained in place. There was no impact on any patient care as a result of the planned decommissioning of the Manston base.

The standard process of communication and information sharing therefore continued between the Department of Community Mental Health and Sgt Hills' Chain of Command, with the Senior Medical Officer and Unit Medical Officer attending the Unit Health Committee and Station Personnel Support Committee.

In light of my response to the specific concerns you have raised, I hope that you are reassured about the seriousness with which the MOD regards Regulation 28 letters. The MOD greatly values Coronial oversight. We are committed to being a learning organisation and supporting service personnel and their families, especially where, tragically, a death occurs. As in society as a whole, the Armed Forces will never be able to eradicate the incidence of suicide: however, we must ensure we continue to reduce the risks by tackling stigma, providing education and having easily accessible, rapid and flexible access to mental health support and healthcare services. We are continually examining ways of developing mental health support for serving personnel and the introduction of mandatory mental health training will further help promote mental wellbeing and resilience.

We have improved the support provided to enable our people to recognise the signs of mental health distress in themselves and in others, and to encourage them to seek help earlier. This includes pre and post-operational stress management training; a wide range of psychiatric and psychological treatments; and initiatives such as Trauma Risk Management which provides peer-to-peer support after a traumatic incident.

The MOD is member of the Department of Health and Social Care-led National Suicide Prevention Strategy Delivery Group, working with partners across government to identify ways to reduce the risk of suicide. The Defence Suicide Registry project has begun; this will provide an evidence base to inform a MOD suicide prevention strategy and ensure that any lessons identified can help prevent others from taking their own lives.

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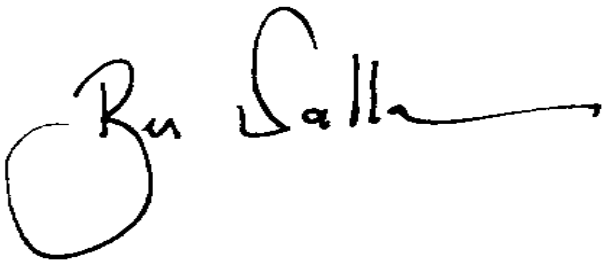
1 [1] RAF Manston formally closed on 31 Mar 99, leaving the site as a Ministry of Defence (MOD) establishment, known as Fire Service Central Training Establishment. It was still managed to a certain extent by the RAF. The site became the responsibility of the Army in 2007 when all 3 Services' (RAF, Army and Navy) Fire & Rescue capability was transferred to Army.

The MOD is also a member of the National Suicide Prevention Alliance, a coalition of public, private, voluntary and community organisations in England, funded jointly by the UK government (NHS/Public Health England) and the Samaritans. The Alliance's focus is on suicide prevention, and to support those affected by suicide.

Thank you for writing me about this important matter. I hope that my response has demonstrated that the MOD has learned and will continue to learn lessons from the tragic death of Sgt Hills. I hope too that Sgt Hills' family will draw some comfort from the knowledge that your report has prompted action.

Yours sincerely,



THE RT HON BEN WALLACE MP