Department of Health & Social Care

From Maria Caulfield
Parliamentary Under Secretary of State for
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Mr Andrew Bridgman
Coroner's Court
1 Mount Tabor Street
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3 February 2023

Dear Mr Bridgman,

Thank you for your letter of 17 July 2022 about the death of James John Jude Booth. I am replying as Minister with responsibility for Mental Health.

Firstly, I would like to say how saddened I was to read of Mr Booth's death, and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention. I share your concerns about patient safety in inpatient mental health settings. Patient safety remains our top priority and it is vitally important we learn from any mistakes made to improve care across the NHS and protect patients in the future.

I note that your regulation 28 report to prevent future deaths was issued to the Department to respond to the matters of concern raised around the security of outside areas of mental health wards, and to the Priory Group to respond to your concerns around information sharing and exchanging in its services. I therefore write specifically on those concerns addressed to the Department.

In preparing this response, Department officials have made enquiries with NHS England. It informs me, with information gathered via Greater Manchester Integrated Care Board (now responsible for health care commissioning in Altrincham), that the Priory Group has taken a range of actions in response to Mr Booth's death. This includes improving security around access to the garden area of Tatton Ward. I hope that, in its reply to your regulation 28 report, the Priory has been able to, or will be able to, assure you of the steps it has taken already to improve safe access to the Tatton Ward Garden.

With regard to patient safety broadly, it is important that patients are treated in settings that are therapeutic and as unrestrictive as possible, with due consideration given to individual patient risk.

Physical security measures such as internal and external perimeters are one of a range of measures that can ensure the safety of patients in mental health settings. The others being procedural measures, such as the timely, correct and consistent application of effective

operational procedures and policies; and relational measures, i.e., the understanding and use of knowledge about individual patients, as well as the environment and population dynamic. Ensuring individual patient safety should therefore include an assessment of individual risk and the appropriate and timely keeping of patient notes that are shared with those involved in the individual's care. It is crucial that services utilise the full range of patient safety measures to prevent patients harming themselves and/or others.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), which is funded in part by NHS England, has been collecting in-depth information on all suicides in the UK since 1996, with the overall aim of improving safety for all mental health patients. Based on evidence from studies of mental health services, primary care and accident and emergency departments NCISH has developed a list of ten key elements for safer care for patients. Recommendations that are strongly associated with reducing suicide rates includes creating safer wards, such as by:

- Implementing effective procedures and staff training to ensure in-patient observations are carried out in a skilled way;
- reducing leave from the ward without agreement though CCTV monitoring of entry and exit points, effective staffing and observation points, standard response for patients who do go absent without leave; and
- acknowledging the importance of balancing patient experience and risk of patients leaving the ward.

NCISH has published a toolkit to be used as a basis for self-assessment by mental health care providers. All mental health trusts in England have downloaded a copy of the tool. It can be found at:

https://documents.manchester.ac.uk/display.aspx?DocID=40697

Turning to perimeter fence/wall height and its role in patient safety, I understand that the Department received a Prevention of Future Death report last year from another coroner, who raised similar concerns. In response to this, officials worked with a range of stakeholders, including NCISH, to explore expanding the evidence base around the role those physical barriers play in patient safety and from this explore approaches to reducing the risk of such absconding. NCISH has updated its patient suicide questionnaire to include information about whether a patient who has died by suicide was able to leave the ward by scaling a physical barrier – a perimeter fence is provided as an example.

With regard to guidance, acute mental health wards, such as Priory Altrincham, are the least restrictive of inpatient mental health settings. They accommodate voluntary patients as well as people detained under section of the Mental Health Act, and therefore current guidance in *Health Building Note 03-01: Adult acute mental health units*[1] (HBN 03-01), whilst mute on the specifics of fence height, states that:

> **3.51** The physical security requirements for the design of an adult acute unit are determined by the need to minimise the likelihood of unauthorised entry and exit […] The location of the service and its layout will also help to determine appropriate safety measures.

[1] https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_03-01_Final.pdf

More broadly, consideration of a patient's safety may extend to considering whether they are in the correct level setting to ensure their safe treatment and recovery. In terms of acuity levels, the next step on from an adult acute mental health unit is a Psychiatric Intensive Care Unit (PICU). There is no Health Building Note covering this, but in 2017 the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) published design guidance[2] and recommendations for commissioners - the minimum height should be three meters.

As you move up the acuity levels in mental health into secure accommodation there are prescriptive standards for fence heights that must be met on the basis of:

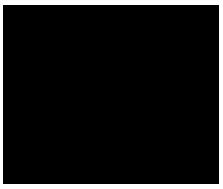
- Low secure services provide care and treatment for patients who present a significant risk of harm to others and whose escape from hospital must be impeded (three meter tall fence);
- Medium secure services provide care and treatment to those adults who present a serious risk of harm to others and whose escape from hospital must be prevented (5.2m fence); and
- High Secure services provide care and treatment to those adults who present a grave and immediate risk to the public and who must not be able to escape from hospital.

Therefore, services with increased security levels are available if there is clinical indication that the person needs to be supported in a more restrictive and secure setting. However, acute mental health wards remain the least restrictive inpatient setting for a person to be supported in.

More generally, Under Regulation 17 of the Care Quality Commission (Registration) Regulations 2009, services must, without delay, notify the Care Quality Commission (CQC) of the unauthorised absence of a person in any location who is liable to be detained under the Mental Health Act 1983. The CQC considers the unauthorised absence of service users as part of its assessment of when and where to inspect services.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Kind regards,



MARIA CAULFIELD MP

[2] https://napicu.org.uk/wp-content/uploads/2017/05/Design-Guidance-for-Psychiatric-Intensive-Care-Units-2017.pdf