Department of Health & Social Care

From Maria Caulfield
Parliamentary Under Secretary of State for
Mental Health and Women's Health Strategy

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[redacted]

Christopher Williams
Assistant Coroner, for the Coroner Area of Inner London South
Southwalk Coroner's Court
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15 March 2023

Dear Mr Williams,

Thank you for your letter of 21 October 2022, to the then Secretary of State for Health and Social Care, Thérèse Coffey, about the death of Daniel O'Sullivan. I am replying as Minister with responsibility for Mental Health and thank you for the additional time allowed.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr O'Sullivan'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.

In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission. I am also aware that the Central and North West NHS Foundation Trust has replied in depth regarding their response since the death of Mr O'Sullivan.

As noted in your report, Central North West Hospital NHS Trust (CNWL) conducted a Serious Incident Investigation Report with regard to Mr O'Sullivan which addressed some areas of concern.

With regard to safety planning, the Trust have recommended the use and implementation of Safety Planning for all patients in the psychiatric ward. The Ward Manager will review and ensure that the ward has a robust system in place to ensure that risk assessments are conducted for all patients in a timely manner.

The Trust has also recommended the implementation of a system to strengthen the process of recording patient leave. All ward staff will be regularly reminded by the Ward Manager of the importance of adherence to the Trust Leave for Informal Patients Policy and Missing Informal Patient Policy. The staff will also be reminded by the Ward Manager to adhere to Trust policy on searching patients at higher risk of having dangerous articles and potential weapons.

With regards to your concerns about the Care and Treatment Plan of psychiatric patients, formulation of a care and treatment plan is not currently a statutory requirement, under the Mental Health Act Code of Practice, inpatients should have a personalised care and treatment plan as part of the Care Programme Approach, and this should be recorded in the patient's notes. The care and treatment plan should include an assessment of the potential risks the patient poses to themselves and/or others and what should happen if the patient is in crisis. I am sorry to hear that this did not happen in Mr O'Sullivan's case.

We are aware through the independent review of the Mental Health Act and subsequent White Paper consultation, and according to the Care Quality Commission, that care planning is sometimes not to the high standards required by the Code of Practice. This is why the draft Mental Health Bill, which was published on 27 June 2022, proposes a statutory duty on clinicians to create a care and treatment plan for all relevant patients detained under the Mental Health Act (including, but not limited to, section 2 and section 3 patients), to help ensure that greater respect and attention is given to care and treatment planning.

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

Kind regards,

MARIA CAULFIELD MP