Department of Health & Social Care

From Maria Caulfield
Parliamentary Under Secretary of State for
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21 June 2024

Dear Joanne,

Thank you for your Regulation 28 report to prevent future deaths dated 26 April 2024, about the death of Charlie Millers. I am replying as the Minister with responsibility for mental health and patient safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Charlie's death and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

Your report raises concerns over the way in which deaths of people detained under the Mental Health Act 1983 are investigated.

In preparing this response, departmental officials have made enquiries with NHS England and the Care Quality Commission.

All healthcare providers must notify the Care Quality Commission (CQC) when a person has died while being detained (or liable to be detained) under the Act. In addition, NHS England must notify the Department of the death of a child or young person in inpatient children and adolescent mental health service settings. This includes those detained under the Act and those in the care of a mental health setting as a voluntary patient. When the Department is informed by NHS England of any such death, the Department immediately notifies the CQC , which reviews the information and determines its regulatory response. It also notifies the National Confidential Inquiry into Suicide and Safety in Mental Health, which records all cases of inpatient deaths amongst adults and children and young people and routinely analyses them to establish the position nationally and make recommendations on what needs to be done to prevent further deaths.

Following Charlie's death, CQC carried out a full review of his death and did not identify any provider failings under which to pursue a criminal prosecution.

Whilst it is the case that there is no requirement for an independent investigation to be held into deaths of people detained under the Mental Health Act, the guidance relevant at the date of Charlie's death - the NHS Serious Incident Framework March 2015 (Appendix 3) - was clear in advising that an Independent Investigation should be considered in the case of:

> "Deaths (and near deaths resulting in severe harm) of those detained under the Mental Health Act (1983) and, in certain circumstances, the deaths of informal psychiatric in-patients where; - the cause of death is unknown; and/or - where there is reason to believe the death may have been avoidable or unexpected i.e. not caused by the natural course of the patient's illness or underlying medical condition when this is managed in line with best practice. This includes suicide and self inflicted death (NB: this also includes the death of recently transferred prisoners. Healthcare providers must inform the relevant prison service if there is reason to suggest that the care they received in prison could have contributed towards their death.)"

The full guidance is available at: https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

NHS England has recognised that the Serious Incident Framework required improvements in relation to learning from incidents. The introduction of the Patient Safety Incidence Response Framework in 2022 represents a significant shift in the way the NHS responds to patient safety incidents increasing the focus on how incidents happen and the factors that contribute for the purpose of learning and improving patient safety. It is the responsibility of providers to ensure their organisation meets national patient safety incident response standards, to ensure the Framework is central to overarching safety governance arrangements and quality assure learning response outputs.

From April 2024 it became a contractual requirement under the NHS Standard Contract for providers, including mental health providers, to implement the Patient Safety Incident Response Framework, which can be found at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf)

The Serious Incident Framework makes clear that investigations need to be undertaken by appropriately trained and resourced staff and/or investigation teams that are sufficiently removed from the incident to be able to provide an objective view. In relation to Charlie's death, Greater Manchester Mental Health NHS Foundation Trust undertook a Root Cause Analysis investigation in line with the NHS Serious Incident Framework process to mitigate against further reoccurrence and share identified learning. This was led by an RCA-trained investigator, supported by two consultant psychiatrists.

Subsequent to this investigation, the Trust (rather than NHS England as stated in your report) commissioned an independent review to investigate the deaths of Charlie and two other young people led by an external Consultant Psychiatrist. The purpose of this review was to identify themes, further learning, omissions and recommendations. The review was supported in principal by NHS England in its regulatory role.

In addition, NHS England commissioned an Independent Review into the care and treatment provided by Greater Manchester Mental Health NHS Foundation Trust following failings within the Trust's services. NHS England asked Professor Oliver Shanley OBE to lead the Independent Review, as the Independent Chair. The review was commissioned with the aim of understand what had gone wrong in the organisation and to make recommendations to prevent reoccurrence, and to bring clarity and reassurance to patients, their families, and staff, as well as the broader public, in respect of the ongoing safety of services that the Trust delivers. As part of the review process the Independent Chair made contact with Charlie's family, to understand their experiences of the care Charlie received.

The Review's report was published in January 2024 and is available at: https://www.england.nhs.uk/north-west/our-work/publications/ind-investigation-reports/independent-review-gmmh-nhs-ft/

Since 2017, Trusts have been required to implement NHS England's *National Guidance on Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*

The purpose of the guidance is to help standardise and improve the way acute, mental health and community NHS Trusts identify, report, review, investigate and learn from deaths and engage with bereaved families and carers in this process. This guidance includes the governance process Trusts should follow, including case record review and investigation following recognised methodology. Trusts are required to collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting in each quarter. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, Trusts need to provide estimates of how many were judged more likely than not to have been due to problems in care. Also published with the guidance is a suggested dashboard which provides a format for data publication by Trusts.

This guidance is available at: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf.

NHS England has also shared details of the wider strategic interventions that it has put in place. Greater Manchester Mental Health NHS Foundation Trust is already receiving support to make improvements to the quality of its care as part of the NHS England Recovery Support Programme.

The importance of rigour required when undertaking, recording, documenting, and auditing observations has been acknowledged and this forms a significant area of work as part of the Improvement Plan that has been put in place by the Trust and the oversight and monitoring of the Improvement Plan by NHS England's System Improvement Board. As part of this improvement work, the Trust has appointed an Improvement Director to support this work.

The Improvement Plan includes a workforce establishment review for nursing, based on the national Mental Health Optimal Staffing Tool (MHOST). This work is progressing, and the tool embraces all the principles that should be considered when evaluating/implementing decision support tools described in *Safe, sustainable and productive staffing: An improvement resource for mental health first assessment* and the results formed part of the enhanced recruitment plan for the Trust.

Finally, a new statutory medical examiner system is being rolled out across England and Wales to provide independent scrutiny of deaths, and to give bereaved people a voice. From 9 September 2024 all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. Medical examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths.
- ensure the appropriate direction of deaths to the coroner.
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased.
- improve the quality of death certification.
- improve the quality of mortality data.

Medical examiners' conclusions can inform learning to improve care for future patients, or, in a smaller number of cases, may be referred to others for further review. Their involvement also provides reassurance to the bereaved. They will provide independent scrutiny, taking a proportionate review of relevant medical records, interact with the doctor completing the Medical Certificate of Cause of Death and interact with the bereaved, providing an opportunity to ask questions and to raise concerns.

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

Yours sincerely,

MARIA CAULFIELD