[redacted]
Parliamentary Under Secretary of State for
Mental Health and Women's Health Strategy

39 Victoria Street
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[redacted]

Department of Health & Social Care

Our Ref: PFD – 24-05-17 - Monoja

Mr Xavier Mooyaart
Assistant Coroner, Inner South London
Southwark Coroner's Court
1 Tennis Street, London
SE1 1YD

28 June 2024

Dear Mr Mooyart,

Thank you for your Regulation 28 report to prevent future deaths dated 17 May 2024 about the death of Mr Jada Monoja. 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 Jada'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 how the risk assessment tool on the Trust's Electronic Patient Journey System (EPJS) is used.

The specific details of your concerns should be addressed in the responses from the Oxleas NHS Foundation Trust and NHS England. However, we recognise the issues associated with the use of risk assessment tools in the care of people who may be at risk of suicide. The ability of clinicians to identify and manage an individual's risk of suicide is critical to enabling treatment and longer-term support that can help to reduce suicidal risk. However, risk assessment tools and scales, used in isolation, cannot accurately predict risk of self-harm or suicide and any use of such tools must only be as part of a wider, person-centred conversation to best understand and assess an individual's suicidal risk.

In September 2022 the National Institute for Health and Care Excellence (NICE) published updated guidance on *Self-harm: assessment, management and preventing recurrence* (NG225). This states that risk-assessment tools and scales should not be used to predict future suicide or repetition of self-harm and should not be used to determine who should and should not be offered treatment. Furthermore, NICE's guidance is clear that the focus of assessments should be on the needs of the individual and how to support their immediate and long-term psychological and physical safety.

In September 2023, the 5-year Suicide Prevention Strategy for England was published, which included over 130 actions aimed at reducing the suicide rate within two and a half years. As part of this, a number of groups were identified for consideration for tailored or targeted action at a national level, including people in contact with mental health services.

It is important that culture and practice across mental health services reflects an individualised, person-centred approach to safety-planning and risk management, and that access to appropriate support is not closed off as a result of assessments of risk. One of the key actions set out in the strategy is that NHS England would identify opportunities to improve the quality and culture of risk management and safety planning within mental health services. The position regarding risk assessments was included in wider guidance to improve care standards for mental health inpatients published in April 2024 and available at: *Culture of care standards for mental health inpatient services*. The strategy also stated that NHS England would scope and start delivery of training and quality improvement programmes.

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

Yours sincerely,