Department of Health & Social Care

[redacted]
Parliamentary Under Secretary of State
For Patient Safety, Women's Health
and Mental Health.

39 Victoria Street
London
SW1H 0EU

[redacted]

Our Ref: [redacted]

James Bennett
Area Coroner,
Birmingham and Solihull
Steelhouse Lane,
Birmingham,
B4 6BJ

By Email: [redacted]

6 September 2024

Dear Mr Bennett,

Thank you for your Regulation 28 report to prevent future deaths dated 3 June 2024 about the death of Tcherno Bari. 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 the death of Tcherno Bari and I offer my sincere condolences to his family and loved ones. I am grateful to you for bringing these matters to my attention.

Your report raises concerns about missing persons policy and Right Care, Right Person (RCRP), and I note that you have directed your report to the Department of Health and Social Care (DHSC) as a party to the National Partnership Agreement (NPA) on RCRP. I also note that you have raised concerns with other relevant partners, including representatives from Birmingham and Solihull Mental Health NHS Foundation Trust, West Midlands Police and NHS England. Given the operational independence of police forces and the autonomy of clinical decision making, those partners are best placed to respond to some of the concerns you raise. DHSC does have a role in setting guidance and direction to the mental health sector and I will respond on these points in particular.

I understand that the NPA, signed by the previous government, set out a collective agreement from DHSC, Home Office, policing, and NHS England to implement the principles of RCRP to end the inappropriate involvement of policing in mental health matters. The NPA did not set out a timeframe for areas to implement RCRP, instead stressing the importance of local partners working collaboratively to plan implementation to ensure that patient safety is maintained. The NPA stated that 'it is crucial that at the heart of planning and implementing

RCRP for people with mental health needs, there is a focus on ensuring patient safety is maintained and people in mental health crisis are not left without support.' It also emphasised that the NPA and RCRP are 'not statutory and do not seek to override legislation, regulations, or statutory guidance that the police or health and social care partners are subject to.'

Local policies should always be developed in accordance with the obligations set out in the Mental Health Act Code of Practice. The Code of Practice is clear on processes for missing persons.

For example, Section 28.15 of the MHA Code of Practice sets out that 'the police should always be informed immediately if a patient is missing who is considered to be particularly vulnerable'. Moreover, Section 28.11 requires that "Hospital managers should ensure that there is a clear written policy about the action to be taken when a detained patient, or a patient on a CTO, goes missing. All relevant staff should be familiar with this policy. Hospital managers should agree their policy with other agencies – such as the police and ambulance services – as necessary."

It is my understanding that RCRP had not been implemented in the West Midlands area at the time of Mr Bari's tragic death. I would expect that local partners will take the opportunity to reassess their joint processes on risk assessment, communication and escalation in light of your recommendations. I also understand that NHS England runs a working group with colleagues across the regions to ensure that learnings and insights are shared nationally. It is crucial that policing and health partners work closely together to provide an effective and timely response to vulnerable people with acute mental health needs.

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

Yours sincerely,