12 Deputy M.R. Higgins of the Minister for Health and Social Services regarding the recent death of a man who had been under treatment at Orchard House: (OQ.215/2019)

Will the Minister advise Members what lessons have been learnt from the recent death of a man who had been under treatment at Orchard House and whether he accepts the comments made by the family at the inquest that the environment at that establishment could have contributed to the man's death; and will he state what steps is he taking to ensure that there will be no repetition of these circumstances?

Deputy R.J. Renouf of St. Ouen (The Minister for Health and Social Services):

My Assistant Minister, Senator Pallett, will answer this question.

[11:15]

Senator S.W. Pallett (Assistant Minister for Health and Social Services - *rapporteur*):

Can I thank Deputy Higgins for giving me the opportunity to respond to the recent sad death of a person who had been receiving care at the Island's inpatient unit? Please can I begin by extending my deepest sympathies to his family and friends; we are a small Island community and a death like this has wide reverberations? I understand from the inquest that this gentleman had a complex and fluctuating response to being cared for at Orchard House. He is described as stating that it made him feel safe and that he wanted to be there and at other times he felt bored. The family, though, had valid concerns about the environment on the ward, which we accept. Orchard House has suffered from historic underinvestment and from staffing issues and our focus has been on prioritising clinical risk management, rather than the therapeutic aspects of care, or the fabric of the building itself. Residents of Orchard House have been in receipt of good, safe, care but this has not been in the best environment. We are learning from the past and holistic care of patients is now the priority. The Mental Health Improvement Board, on which I sit, is overseeing these changes. The proposed Government Plan emphasises the importance of improving the quality of mental health care. Briefly, I would like to outline some of the changes that are already happening. We now have a robust framework for monitoring improvements. The Jersey Nursing Assessment Accreditation system is a vehicle for assessing, monitoring and providing assurance around patient care in clinical areas. A senior occupational therapist has been newly appointed and is going through their induction and will be based on the ward from this month. The Occupational Therapy Service is commencing staff training on Triangle of Care this month. The approach will support better partnership working between service users, their carers and Health and Community Services. H.C.S. (Health and Community Services) is already working with Mind Jersey on well-being and on approaches to peer support with the Jersey Recovery College. Two new *locum* mental health social workers are starting this month and their energies will be divided between the Community Mental Health team and Orchard House. I hope this can assure the Deputy that lessons have been learned and that improvement in all areas is ongoing.

Deputy M.R. Higgins:

I would like to thank the Assistant Minister for his answer, one for expressing condolences to the family, secondly for acknowledging that the facilities are not adequate and also for outlining the improvements he hopes to make. I will watch with interest, but thank you very much for the answer.

3.12.1 Deputy K.F. Morel:

I just want to ask more directly, really, whether all deaths of patients, even when they are released for the weekend, things like this, or sent home for weekends, whether they are all reviewed by Mental Health Services. I ask this, because I know of one person who was released over the weekend, no relatives, no friends were informed of this and they took their life. They have no idea if this has even been looked at by Mental Health Services. So, are all deaths, even if not on Department of Health property, looked into?

Senator S.W. Pallett:

All deaths, certainly unexplained deaths, will be a matter for the Coroner and that is probably the way that Mental Health Services would be involved and any lessons learned from that. In terms of any particular patient, it depends on the individual patient, some have the capacity and they have every right to leave the facility. We do offer the care and support within the community that they need and that support is improving day by day, month by month. But in terms of do we investigate every single death within the department, I think the answer would have to be no, but there are lessons to be learned from when there is an unexplained death, as this was and Mental Health Services have an opportunity to feed into the Coroner's inquest and lessons can be learned from that.

3.12.2 Deputy K.F. Morel:

Would the Assistant Minister explain how, if the department does not look into the deaths of all patients under their care at the time, how the department will ever learn lessons? Because, in this case, simply phoning relatives, or phoning friends, to let them know this vulnerable person had been allowed home for the weekend would probably have prevented this death, yet, except for the Coroner, why is there no automatic review?

Senator S.W. Pallett:

The Deputy knows that is not what I said. If a patient is under the care of H.C.S., Health and Community Services, there certainly would be an investigation as to why a person had taken his own life, or if there had been an incident. But, clearly, if somebody has voluntarily left, in this case Orchard House, they are under the wider care of the Mental Health Services, but not within the facility itself, then there are other ways, as I have already said, that we can learn lessons. But, certainly, if any patient is in the care of H.C.S., there will be an investigation if there is a death, whether it be in the hospital, or whether it be in an institution. But this particular person was free to leave Orchard House and unfortunately took his own life, of which I have already said I give my deepest sympathies, as we all would. But that is a choice he made to leave that facility.

3.12.3 Deputy K.G. Pamplin:

In response to a question I asked earlier this year, it was confirmed there was ongoing remedial works, including pedestrian walkways, enhancing the lighting and signage, replacing staff alarm systems, staff working with patients and improving the garden area to create a more pleasant outside environment; I could go on. Is this on target to be completed by the end of this year, can the Assistant Minister confirm?

Senator S.W. Pallett:

I should just get up and say yes, because the answer is yes. There are safety improvements that had to be dealt with as a matter of urgency; they have been carried out. I know there have been improvements to the aesthetic side of the building, but there is still some more work to do, of which

I am pressing hard to make sure it is completed by the end of this year. So, I can give assurances that I am putting officers and all the States bodies that are involved in doing that work under pressure to make sure that we provide an environment at Orchard House that is suitable for patient care. I am also putting pressure on other States departments to ensure that, for example, the planning application for Clinique Pinel is on time and the work at La Chasse, which is equally important, is also run on time. So, I can assure the Deputy that I am not giving up on anything in terms of timelines to make sure that we provide services that are required.

Connétable S.A. Le Sueur-Rennard of St. Saviour:

My question has been answered and asked by Deputy Pamplin.

3.12.4 Deputy M. Tadier:

First of all, can I thank Senator Pallett for a clear and comprehensive answer and it is a shame, really, that the Minister did not consider making a statement on this issue today, as there seems to be new policy being announced today on World Suicide Day and maybe he will yet consider making a full statement this afternoon, or later, on mental health, so that we can have more of a discussion on this important issue? The saddest case that I have probably come across in my time in here was a youngish man who was also an addict but had mental health issues and he had been asking to get help, to go into Orchard House, because he said that he was feeling suicidal and that he had thoughts. That gentleman did eventually take his life, because he could not get the access; he was told that he could not go to Orchard House, it was not appropriate for him. Is there a way to record, because of course all of these are individual cases and any case is tragic, but we also need to be able to record these incidents, so that we can know how prevalent they are? So, do we know the extent of people in our society who are asking to access mental health facilities, or other kinds of help, who are being told that they cannot access them and then go on to self-harm, or to commit suicide, as a result?

Senator S.W. Pallett:

First, if Deputy Tadier has any information on an individual, I would happily look into that and if mistakes have been made, or lessons to be learned, I will happily learn them, as will our new senior medical team at Mental Health Services. In terms of access to services, we are looking to improve that day by day, so that people do not get in a situation where they need acute services. Every individual is different; every individual needs a service and care that suits them. Unfortunately, there are levels of care that we do not provide in the Island currently and it leads to unnecessary worry and unnecessary worsening of conditions, which could be dealt with at an earlier stage. But again there are some new proposals coming forward, for example around Listening Lounge, which we have all been looking forward to for some time, which will offer opportunities for people to access services when they need them, at the time they need them and not have to wait to get them and their condition worsens. I find it distressing when I hear people have to wait months to see somebody to talk about their mental health, or an issue in their life. That is not acceptable. I know that is not acceptable. But putting it right overnight is difficult and I know with the associate medical director - I speak to him 2 or 3 times a week - we are determined to make sure that people can get the services they need when they need them.

The Deputy Bailiff:

A final supplementary, Deputy Higgins?

Deputy M.R. Higgins:

No.